EXHIBIT "A" - Papin Deposition

Joseph Papin v. University of Mississippi Medical Center, et al.

Joseph Papin

January 22, 2021

All depositions & exhibits are available for downloading at
<www.brookscourtreporting.com>
Please call or e-mail depo@brookscourtreporting.com if you need a **Username** and **Password.**

Mississippi - Louisiana - Tennessee - New York
1-800-245-3376

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

JOSEPH PAPIN

PLAINTIFF

V. CIVIL ACTION NO. 3:17-CV-763-CWR-FKB

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER; DR. LOUANN WOODWARD, IN HER OFFICIAL CAPACITY; AND DR. T. MARK EARL, IN HIS INDIVIDUAL CAPACITY

DEFENDANTS

DEPOSITION OF JOSEPH PAPIN

Taken at the instance of the Defendant at Whitfield Law Group 660 Lakeland East, Suite 200 Flowood, Mississippi 39232, on Friday, January 22, 2021, beginning at 9:30 a.m.

REPORTED BY:

ROBIN G. BURWELL, CCR #1651

APPEARANCES:

C. RYAN MORGAN, ESQ.
Morgan & Morgan
20 North Orange Avenue, Suite 1400
Orlando, Florida 32801
rmorgan@forthepeople.com

COUNSEL FOR PLAINTIFF

TOMMY WHITFIELD, ESQ.
Attorney At Law
660 Lakeland East, Suite 200
Flowood, Mississippi 39232
tommy@whitfieldlaw.org

COUNSEL FOR DEFENDANT

INDEX

EXAMINATIONS

EXHIBITS

JOSEPH PAPIN,

having been first duly sworn, was examined and testified as follows:

EXAMINATION BY MR. WHITFIELD:

Q. Would you state your name for the record?

A. Joseph Edward Papin, IV.

Q. I'm sure your attorney has kind of gone over with you how a deposition works. But, have you ever sat for a deposition before?

A. No, I have not.

Q. I'm going to be asking you questions under oath. We need you to answer yes or no. Head shakes and uh-huhs and huh-huhs don't really translate well because she has to take it all down. Also, please let me finish my question and then answer. And I'll try to let you finish your answer before I ask the next question. Because she gets really mad when we talk over each other, and it messes up her record. We want to keep her happy today.

We'll go through this and we'll take breaks probably every hour, hour-and-a-half, just to give you a chance to refresh and regroup. If you need a break at anytime, just let me know.

This isn't a sprint, isn't a marathon. So if you need a break, let me know. I only ask that you answer the question that's on the table before you take the break.

A. Okay.

Q. I'm going to copy from my colleague here and ask you two questions. Have you ever been convicted of a crime?

A. No.

Q. Are you under the influence of any drugs or medication that would prevent you from answering truthfully today or affecting your memory?

A. No.

Q. Let's get started. Will you tell me where you're living now.

A. Orlando, Florida.

Q. And how long have you been in Orlando?

A. Grew up there, but most recently I came back in May of 2020. May, June-ish.

Q. Where were you before May?

A. Ann Arbor, Michigan.

Q. How long were you in Ann Arbor?

A. Two years, approximately.

Q. And before that, where were you?

A. Florida.
Q. Back in Orlando?
A. Yes, Orlando area.
Q. How long were you there?
A. That would have been, I want to say, June 2017 through June-ish 2018.
Q. And before that, where were you?
A. Brandon, Mississippi.
Q. And how long were you in Brandon?
A. It was June 2016 to June 2017, or June 1st, 2017, if I remember correctly.
Q. And before Brandon?
A. Before Brandon, I was in Ann Arbor, Michigan.
Q. How long were you in Ann Arbor?
A. That would have been five years.
Q. And before that?
A. Gainesville, Florida.
Q. How long were you in Gainesville?
A. Four years.
Q. Starting in Gainesville going back the other direction, why were you in Gainesville?
A. I was an undergraduate at the University of Florida.
Q. What made you move to Ann Arbor?

A. Medical school.
Q. I see you were in Ann Arbor five years. Medical school is four. What did you do for the extra year?
A. I did a post-doctoral fellowship in house services research.
Q. And what brought you to Mississippi?
A. Surgical residency.
Q. And then for the year that you were in Florida from June of '17 to June of '18, what were you doing then?
A. Living with my parents.
Q. Were you working anywhere?
A. No.
Q. Why didn't you seek employment?
A. During that time?
Q. Uh-huh. (Affirmative response.)
A. I did seek employment during that time. I sent out applications to a few consulting companies, sent applications to similar types of companies, to consulting companies, things like that. I didn't even get an interview offer.
Q. Did you attempt to re-enter the match in 2017, 2018?
A. 2017 -- by the time I was terminated

from Mississippi, it was too late to enter the match. So 2017, no. 2018, no as well.

Q. What about 2019?

A. 2019, I did.

Q. Is that entering in 2019 to match in 2020 or entering in 2018 to match in 2019?

A. That's a good question. So it would have been -- so the application would have gone out -- if I remember correctly, it would have gone out towards the end of 2018 to begin July of 2019. So entering class of 2019.

(Exhibit 1 marked for identification.)

Q. (By Mr. Whitfield) I'm going to hand you now what's been marked as Exhibit No. 1.

A. Thank you.

Q. This is a document that was provided by your lawyers in discovery for entering the match.

A. Okay.

Q. And it looks like this was entered on January 7th, 2020.

A. Okay.

Q. And you applied to, looks like, nine different programs?

A. Ten.

Q. Is this the entry into the match that

you're referring to?

A. Yes.

Q. So it was actually in 2020, and not --

A. So this would have been -- okay. So this would have been for entering class of 2020 then. That's correct.

Q. Entering class of 2020 or entering class of 2021?

A. That is a good question. So the date on this is Thursday, May 28th, 2020. Oh, right. So this would have been the entering class of 2020, because I believe --

Q. According to this, there's only about a month between the date you applied and the entering class of 2020.

A. Right. I don't know what this -- is this -- so this is ERAS, and this was on the -- so the invoice is from -- ours is a little confused. At the top it says May 28th. I assume that's the retrieval date. And then on the invoice it's from January 7th, 2020. So this would have been for the match class entering 2020.

Q. Don't they do interviews and all of that before January of 2020?

A. You can. Certainly they go through --

usually the season is December through February, if I remember correctly, is the interview season. Applications open sooner than that, and then most programs enter between December and February.

Q. So to go back to what we were talking about a minute ago, you did not apply back to the match for the 2018 year and you did not apply for the match for the 2019 year?

A. That's correct. It was not 2018, not 2019. It was 2020.

Q. And did you get any interviews or match anywhere?

A. I did not.

Q. Now, I believe there are many, many programs to match into. Why did you only select 10?

A. Well, cost is prohibitive, and I felt like I was, you know -- had there not been this sort of black cloud, I felt like I could have been competitive for a good amount of these programs. But, you know, cost -- the way that the programs are set up is you buy them in bundles. I can't recall the exact bundles, but it's like you buy 10, it's a certain price; you buy 25, it's a much more; you buy another 25, much, much more. Things

like that.

Q. Now, it doesn't reflect on here, but was this only for categorical matching?

A. Yes, I believe so.

Q. Why did you not enter for a preliminary spot?

A. I wasn't interested in a preliminary spot.

Q. Did you apply to any other specialties?

A. No. I wanted to be a surgeon my whole life. I had trained and done the necessary things to become a surgeon. So surgery was, within medicine, what I wanted and still would like to be.

Q. Now, the year after you graduated from med school you said you did a post-op research fellow. Did you not enter the match that year?

A. The year -- sorry, can you --

Q. For your senior year, did you enter the match to match going out of med school?

A. I did.

Q. Did you match anywhere?

A. I did not. That was in neurosurgery.

Q. So because you didn't match in neuro, you took a research year?

A. I mean, I had been planning on it, but, you know, once I didn't match, I needed something to do. So I wouldn't say that it was definitely the cause of it, but, you know, be something to do that year.

Q. Why didn't you reenter the match for the 2018 and the 2019 cycles?

A. I was in business school, so I had -- when I was dismissed from the University of Mississippi I studied for the GMAT, took the GMAT, was admitted to the University of Michigan's law school of business. Went to business school. I had been advised by several people that having been dismissed -- anytime that you -- when you go to apply to a program, you have to check a box that says you've been dismissed from a program. And that pretty much disqualifies you from just about everything.

Q. Who are these people that advised you that?

A. Some fellow classmates of mine.

Q. What are their names?

A. I don't recall. It's been four years since then. But, you know, my own intuitive sense, when you click in -- surgery, medicine in

general, sometimes there's 5,000 applications for a single seat. So if somebody has -- I've been dismissed from a program, I've been labeled a danger to patients, they'll go to one of the other 4,999 applicants.

Q. So this never came from anywhere official, it came from your classmates and your own intuition?

A. There's no official source of information. There's no official mentor, you know, like program where you go and you tell someone your statistics and they'll guarantee you a match or anything like that. Official as it could be, but there's no official -- nobody is official and nobody can tell where you're going to end up or how you'll end up.

Q. But you didn't get that from a program director or somebody working inside a surgery program, you got that from your classmates?

A. Things like that, yeah. So that was another question, if I start to speak to people about surgery and about my history, it could then close the loop or close that as an avenue for me applying to surgery programs. So, if I tell a program director in surgery, hey, what do you

think, this is what happened, it might be prejudicial and they may no longer want me.

Q. That was a decision you came to on your own?

A. No. Again, these were things -- me partly, yes, but they were things that others advised too. Just intuitively being labeled a danger to patients as a doctor, it's a Scarlet letter, nobody wants it, nobody would want it for anybody else.

Q. So instead of trying to continue your medical career you decided to go to graduate school?

A. Not instead of. I went to graduate school, but not instead of my medical career.

Q. Well, you didn't apply to the match which is what you had do to move forward?

A. Well, you don't need to go into the match as far as I have learned. So you can also send applications outside of the match. It's easiest and the most organized way is through the match, but once you work -- I believe if you complete six months of your residency -- and this is me, this is kind of a supposition because I'm not giving you guaranteed information, but I

believe that you can apply outside of the match if spots open up outside of the match.

Q. And how many schools did you apply to outside the match in 2018?

A. None.

Q. How many did you apply to in 2019?

A. None.

Q. 2020?

A. Outside the match, none.

Q. So if a program didn't fill all of their available spots, you would apply outside the match?

A. So in -- there's another match for that, it's called the SOAP, the supplemental something, something. So if you go through the match and you as a program have open spots, there's SOAP positions that you then funnel those into the SOAP. Outside of the match would be like a surgery resident or, you know, quit or was fired seven months in and now they need that spot filled. So they have an opening. And they advertise it just like you would, you know, for a job anywhere else.

Q. Did you apply through any of the SOAP positions in 2018?

A. No, I don't believe you can enter the SOAP unless you've entered the match.

Q. So I'm assuming the same for 2019?

A. That's correct.

Q. And in 2020, did you apply for any of the SOAP positions?

A. No. I think the SOAP -- no. I don't believe there were -- and this is just me remembering, but in 2020, I think I looked and there were no SOAP positions available. I think surgery filled its compliment in 2020. And they generally do. It's a competitive match.

Q. What kind of employment have you had since leaving the Med Center?

A. I -- let's see. I want to make sure I give you the right dates this time. In June of 2019, I started as an intern for Accenture Strategy as a senior consultant -- senior strategy consultant. Worked there -- it was planned to be three months, I worked there three months. I believe June, July, and a little part of August. Then I went back to the MBA program. That's kind of a standard route, you do a summer internship. And then I got a return offer and took that, and then came back to work for Accenture in October of

2020. And have been working there ever since.

Q. What do you do for Accenture?

A. I'm a senior strategy consultant.

Q. What does that do?

A. So you advise on gross strategy. If a company comes to you and they'd like to figure out, you know, where they would want to go with their company, whether they want to acquire others, whether they want to, you know, make a new product, cut out a product line, mergers and acquisitions, helping to integrate companies together, things like that.

Q. Any particular field of companies?

A. Generally life sciences companies is what I've done. You can align eventually to where you have a specialty. It just so happens that mine have all been in life sciences companies.

Q. Define more about what life sciences companies is?

A. Like pharmaceutical companies, things like that.

Q. And is that something that they wanted your medical background for?

A. No, I wasn't hired specifically because of my medical background for that. In fact, most

of the people that are senior strategy consultants and even higher don't have a medical background. It's just an interest that they may or may not have.

(Exhibit 2 marked for identification.)

Q. (By Mr. Whitfield) I'm going to hand you what has been marked as Exhibit No. 2. Now, is this your current Accenture contract?

A. I just got through the first page here. This looks like the offer letter. This was the offer letter. I don't know if it's, you know, technically called a, you know, the contract and everything like that. But this is certainly the offer letter. And I think this is the letter I signed to accept employment there.

Q. This was in August of 2019?

A. That's right.

Q. But you didn't start work for another year?

A. That's right. So you do your summer internship. I think it's similar -- somewhat similar to what they do in the law. You do a summer internship, then you go and finish your second year, which would have been my last year of business school, and then you start after that.

Q. Do you get paid while you're in business school?

A. No. That would be nice, though.

(Exhibit 3 marked for identification.)

Q. (By Mr. Morgan) I'm going to hand you now what's been marked as Exhibit No. 3. This is your 2019 W2 from Accenture that was provided by you in discovery.

A. That's correct.

Q. It says you made a salary of $85,650.69 in 2019.

A. That's correct.

Q. So you had a summer internship for 24,000?

A. I don't recall that exact number.

Q. You weren't being paid $85,000 for your summer internship.

A. So they give you, obviously, a salary. They give you a bonus for signing. They give you -- and then once you get a return offer, as you can see in Exhibit 2 here, they give you sign-on bonus and a relocation bonus. And that's all within 2019. So that was all counted for income for 2019.

Q. That's your sign-on bonus?

A. Full time.
Q. Your relocation bonus, so now we're up to 35,000, and then your summer intern money?
A. Right. That's correct.
(Exhibit 4 marked for identification.)
Q. (By Mr. Whitfield) I'm going to hand you now what is Exhibit No. 4, which are the answers to your interrogatories that you provided. And in interrogatory No. 11, you state that you were hired as an intern for Accenture with an annual salary of 24,000 with no benefits.
A. Do you know the date of this?
MR. MORGAN: Should be at the very end.
THE WITNESS: The date would be helpful. 24,000 sounds about right for what I made just in base salary. But without knowing the date on this, because I would not have known that I was getting -- what I'm guessing is, is that this was probably before I got the full-time offer.
Q (By Mr. Whitfield) These are your answers, so --
A. Right.
Q. And the supplemental answer with your new lawyers. I'm just asking did you make 24,000 on your summer internship program?

A. Yeah, I'm telling you that sounds right in terms of base salary, but there's bonuses that are not benefits. I interpreted benefits to be health insurance, things like that.

Q. So with the 24,000, the 25,000, the 10,000 relocation bonus, that comes right up to 59,000. So the other 20,000 is bonuses?

A. Yeah. I mean -- I've provided the breakdown, but the only money that I made is from Accenture. The only money they've given me is either in salary or bonuses. So however that breaks down in 2019, I guess the sum of it is $85,650.

Q. From now on it's 155,000 a year plus bonuses?

A. That's right.

Q. How much have you received in bonuses this year?

A. That is new, I think it's just the -- don't quote me on this, but on the last page of Exhibit 2, there's a tuition reimbursement. I don't know that you would call that a bonus, but it's part of the offer where they pay $50,000 towards the second year of your primary degree. To my knowledge, that's the -- I don't consider

that a bonus, it's just a tuition reimbursement. They've given me that, and then just my base salary since being at Accenture full time.

Q. You got a $50,000 tuition --

A. Reimbursement.

Q. What tuition did that apply to?

A. That's for the second year of the MBA program.

MR. MORGAN: For the record, I think we'll be coming up here in the next week or so on getting your 2020 W2 -- or 2021 W2 for 2020, and we'll, of course, supplement that.

Q. (By Mr. Whitfield) Any other jobs or positions outside of Accenture? Any other consulting work or anything of that nature?

A. Since?

Q. Since you left UMC.

A. I don't believe so, no.

Q. Now I want to go back to, you were in the match for the 2016 cycle, I guess to start school in 20 -- is it a 2015 match or the 2016 match?

A. It's confusing. I would assume -- I think it's the 2016 match. It's that -- you start in 2015, but it's to enter July 1st, 2016. I

would believe -- I believe that's considered the 2016 match.

Q. Where else did you apply to match?

A. In general surgery in that match? It's been so long I couldn't tell you, but many programs.

Q. More than 10?

A. You know, I can't recall.

Q. Did you reapply for neurosurgery or just general surgery?

A. Just general surgery.

Q. Did you also apply for categorical and preliminary spots?

A. In 2016?

Q. Yes.

A. You know, I don't recall.

Q. Where all did you interview?

A. In the 2016?

Q. Yes.

A. This isn't going to be a complete list, but the University of Florida, the University of Michigan, the University of Mississippi. There were more, I just can't remember. I would say definitely greater than five interviews.

Q. Who were your top choices?

A. I don't recall that either. I think the University of Florida was probably my top choice. We submit a rank list in order of our -- of where we would want to go. I think the University of Florida was first on my list that year. And then I couldn't tell you what the rest of the list was.

Q. Was UMC toward the top of your list or toward the bottom of your list?

A. Toward the top.

Q. Tell me about your interview with UMC.

A. Anything specifically?

Q. Uh-huh. (Affirmative response.)

A. I'm asking, is there?

Q. Just in general.

A. I really don't recall too much about it. The only things that I recall is I flew in, was picked up by one of the residents who picked a bunch of us up, drove us to our hotel, and the next day we interviewed, and then I flew out that same day.

Q. Do you know who all you interviewed with?

A. I don't know everybody. I can recall a few. I can recall Larry Martin. I can recall Dr. Earl -- Dr. Larry Martin, Dr. Earl, and

Dr. Chris Anderson. There were more, I just can't remember them all.

Q. And then you matched apparently with the University of Mississippi Medical Center?

A. That's correct.

Q. To start July 1 --

A. 2016.

Q. -- 2016.

(Exhibit 5 marked for identification.)

Q. (By Mr. Whitfield) I'll hand you what has been marked as Exhibit No. 5.

A. Sure.

Q. This is your contract with UMC to be a house officer, correct?

A. That's correct.

Q. That's your signature on the back page?

A. Yeah, it looks like it. It looks like this has been scanned a few times, but yeah, it looks like it.

Q. And going to the front page, it's between you and the University of Mississippi Medical Center, and they are going to pay you a salary of $47,738 to be a house officer?

A. That's right, yes.

Q. Of course, you would agree with me

that's less than the 155,000 you're making now?

A. Sure.

Q. You started July 1st, 2016?

A. That's correct. I think officially that was my first day -- looking at this contract, now that I'm looking at it and remembering it, it looks like June 28th was probably -- you go in for orientation, things like that, but July 1st would have been my first day, you know, physically acting in capacity of a doctor.

Q. Do you remember what service you were on to start with?

A. I do. It was the cardiovascular ICU. I was the first ever surgical resident to rotate through there.

Q. Resident or intern?

A. Definitely intern. I believe resident overall.

Q. There was a fellow on that service as well; is that correct, Dr. Miguel Urencio?

A. No. Dr. Miguel Urencio was a fellow in cardiothoracic surgery, but he wasn't on that service. I was in the cardiovascular ICU, he was a cardiothoracic surgeon who -- his job was to basically learn how to operate on cardiothoracic

patients, but he wasn't on the service in any sort of official capacity with us.

Q. Tell me about your first rotation. What did you do, what were your job duties?

A. Sure. So I met with Dr. Shake at the beginning of the rotation, Dr. Jay Shake. He was the attending kind of in charge of the rotation. And he told me that my responsibilities, you know, just briefly were, you know, do what you can on the floor. I realize you're a first month intern, we're not expecting too much of you. Your job is really just to learn. That's really the number one responsibility. And then when -- there will be a lull at some point in the day. If you want, you can go down to the operating room, just go down, learn what you can there, too.

And then in terms of responsibilities, we were assigned some patients. The nurse practitioners -- it was completely a nurse practitioner run service. There's an MD attending presiding over everything, but in terms of the day-to-day things, who handled putting in orders, writing, things like that, those are nurse practitioners. So we would split up the patients. I would see some before they rounded, they would

see some. We would go and round. And then I would be responsible for putting in the notes, putting in the orders, and anything else that might arise throughout the day for them.

Q. We'll talk about this a lot in more detail as we go through this deposition today. Tell me what rounding is.

A. Sure. So rounding is, you get -- and there's different types of rounds. There's pre-rounding, there's table rounding, there's rounding. I'll just go into rounding right now. That's where you get the whole team, the multi-disciplinary team, whatever it is. It's usually an attending and residents, and usually that's the bare minimum. If there's nurse practitioners on the service, they'll come, too.

And you go room to room. Right outside the person's room you'll discuss their case, what's been going on, any updates, anything that's concerning. Then you'll go in and you'll see the patient with the attending. Everyone goes in or just the resident and the attending go in sometimes. And then I would speak to the patient, elicit a history and a physical as necessary, come back out, kind of finalize the plan. Move on to

the next person until the whole list is done.

Q. You mentioned pre-rounding. What is pre-rounding?

A. Pre-rounding is anytime -- you consider rounding in the sense that it's used with an attending physician. Pre-rounding is when you're rounding without an attending physician. So whether that's just me going around, that's pre-rounding. Whether I take a med student, something like that, that's pre-rounding. When a med student goes, they're pre-rounding, too.

Q. Fair to say that pre-rounding is you getting ready to round with the attending?

A. That's correct.

Q. What are your responsibilities on pre-rounding?

A. So pre-rounding, what you want to do is you want to gather, you know, like the vitals from the night before, things like that, how they've been doing, what they look like. You want to look at labs that have come out in the morning. Usually, especially in the ICU, there's routine labs that are drawn. You look at the morning labs. Any imaging that was done since you last saw, if it was overnight, anything like that. And

then you want to -- so that's kind of like the objective part of it, the data that's coming in that's feeding through.

Then you want to go to the human aspect. You go see the patient. That's the subjective parts. You talk to them, see how they're doing, do they have any pain, do they have any new symptoms. Do a physical exam and, you know, repeat that for all the patients on your -- that have been assigned to you.

Q. What does the physical exam consist of?

A. So you -- initially -- it starts when you come into the room. So one of the parts is general, how do they look. Do they look sick, do they look weak, do they look healthy, things like that. So first part of it is observing, and then you kind of -- there's a full physical exam where you touch on every body's parts. You assess strength, you assess their sensation, listen to their heart, listen to their lungs, touch their abdomen, listen to their abdomen, things like that.

And then there's the more directed physical exam, which is what people tend to do after they've already been admitted and things

like that. And you kind of know what you're looking for. If anything is going wrong. You know, if they have a heart issue, you probably want to listen to their heart, for example. You don't need to move their knees about or anything like that to make sure -- because they didn't come in with a knee problem, for example.

So the physical exam, you go system by system -- in general, on these rounds, you go system by system as necessary. So I'd listen, generally -- as a surgeon, we're taught to listen to the heart, taught to listen to the lungs. And most don't even do that because most don't even carry a stethoscope. You listen to the heart, you listen to the lungs, you palpate their abdomen. Because a lot of times what general surgeons are doing is something to do with abdominal organs, in testings, things like that. And ask them how they're doing.

Q. What do you do as far as looking at their charts, x-rays during pre-rounds?

A. So it depends on what you want to do. So everyone has their own personal style. There's no correct way to do it. I would generally, you know -- and it differs by service, too.

Medical students sometimes gather vitals for you. So they come in slightly earlier than you. They'd go through the list, and they'd put in, you know, blood pressure range, this and this, heart rate range, this and this, overnight, which is helpful. And then sometimes they would also put the labs on there for you. So that would sometimes be sufficient to just start your pre-rounds.

You look at the list, you have the labs, you have the vitals, okay, they haven't had a temperature, their heart rate has been good, they haven't had, you know, anything wrong with their labs. So you can go -- you can go and pre-round, get the exam, talk to them, you know, get how they've been doing from them. And then you can sit down -- and the order differs depending on style. Then you can sit down and read notes, anything that's come up, anything like that for yourself so that you're prepared for table rounds. Depending on the service.

Table rounds, you know, the attending can or can't be there sometimes -- or may or may not be there. Usually, it was -- table rounds was all the residents and nurse practitioners, the

whole team minus the attending. We'd all get our patients discussed, things like that, and then we're ready to discuss it with the attending as a whole. And that's going room to room.

Q. All right. See if I can remember all this in order. So you pre-round --

A. Right.

Q. Let me back up. A med student may pre pre-round, then you would pre-round?

A. Right.

Q. Then you may or may not table round?

A. Right.

Q. And then you would meet with the attending and do the formal round?

A. That's right.

Q. As far as giving information to the attending, that's you presenting the case?

A. That's correct. So usually -- it would depend. Sometimes the senior resident might just take over and say, you know, this and this, if they're really trying to expedite rounds, something like that. Usually the resident, the intern whose patient it was, will just present quick story, give some quick updates, things like that. And the senior resident was right there,

they would jump in if they missed anything, things like that. And you would present outside your patient's room. The next patient might not be yours. That resident would take over and start speaking.

Q. Busier services, you divide and conqueror; smaller services, you may have them all. Or if you're only the only intern assigned to the service, you may have them if it's a small service?

A. I've never seen a service where it's just an intern. That would seem unsafe to me. So I've never seen a service where it was just an intern. Generally it was, you know, a few residents, you would split up the list. If there's 60 people, 3 people, 3 residents, whatever, you'd split it up, 20 each.

Q. And then when the attending would come on rounds, you said y'all would go to the room. How did the rounds with the attending work?

A. Sure. So you would meet with the attending usually at the entrance to the floor, wherever it was that you guys wanted to meet, you'd meet. The attending would generally kind of be a follower. The senior resident would lead us

down. Okay, we have a patient here. They would kind of plan out the route. We have a patient here, then -- if it were my patient, I would present on that patient. Then we as a team would usually enter the room. The attending would talk to the patient, do a physical, and we would discuss the plan and move on to the next patient.

Q. When he does a physical, is this an in-depth physical or just kind of a cursory physical?

A. I would say it varied, but the depth was as necessary. I've seen many, many attendings do -- you know, very in-depth physical exams. And then some, if they've only been operated on in their abdomen, all you've got to do is press on the abdomen a few times to make sure nothing is going wrong with the surgery or something like that. I would call that more of an abbreviated exam, but I've seen both.

Q. So on the CV ICU rotation, tell me about that. What is that service?

A. It's the cardiovascular intensive care unit. So generally patients that are admitted that have some sort of really intense heart issue, lung issue, something like that, can be directly

admitted. Or if you've been operated on by a cardiac surgeon, for example, something like that, a heart transplant, whatever, those go to the cardiovascular ICU because these people see cardiac issues much more frequently than others. It's critical patients that are being seen.

Q. Being an ICU -- I'm obviously not a doctor, I'll cop to that all day long. But they're more critical patients than, say, on the standard floor?

A. Absolutely.

Q. They're not -- they may not be on death's doorstep, but they're not well enough to be in just a normal room?

A. Right.

Q. I believe -- somebody said they're in state -- they could be up and down depending on the moment?

A. Not necessarily all of them. It's just people that -- nursing in the ICU. There's a higher -- I believe, at least before COVID, I haven't been in them anymore, but it used to be one-to-one. So one nurse would be responsible for one patient in the room, or maybe two-to-one at most, whereas on the floor it's much more -- one

nurse could be responsible for many more patients. It allows for a high degree of supervision. It doesn't necessarily mean that they're on death's door, anything like that. In some people it's just the natural progression, you have your heart surgery, something like that, you're doing okay enough for a post-heart surgery patient, but you need to be monitored.

Q. That's why you have that one-to-one or two-to-one ratio so they could be monitored all day?

A. Right.

Q. As far as vitals, checking on the patient, needs of a patient, is that done more often in an ICU setting versus a floor setting?

A. Checking on vitals or needs of the patient? Generally you order vitals, you know, like every hour or so, something like that, in the ICU. You can do that on the floor, too. I wouldn't say necessarily that the frequency that vitals are being checked are different in the ICU from the floor.

Q. Are there more -- because it's a one-to-one ratio, is there more expected of a nurse observing a person in the ICU than, say, on

the floor? Are there additional duties associated with being in an ICU?

A. You know, I couldn't comment on exactly what a nurse -- what is expected as to, you know, what a nurse does specifically on the floor versus what they do in the ICU. But, you know, their attention is much less spread out. As a physician, that's all I've noticed.

Q. What about for you as the intern on that service?

A. So I would generally have -- the ICU -- I don't know, it had maybe 10 to 15 beds, something like that, the cardiovascular ICU had maybe 10 to 15 beds. And then not all of those were CV ICU patient. Sometimes, you know, there is a -- there's a surgical ICU, the SICU, sometimes that would get overflowed and they still need ICU care, so they would come up to there. Let's say there's 15 beds, I'm just guessing, not all of those would be cardiovascular ICU patients that we were seeing. So maybe of the 15 we've got 8, 9, something like that. And I would -- as a very, very early intern, first month intern, I had maybe two, three, something like that.

Q. Would you be splitting the nurse load

with the nurse practitioners?

A. That's right.

Q. Let's say there's nine people and there's you and two nurse practitioners, you would be responsible for three and each one of them would be responsible for three?

A. That sounds about right, yeah. But the way that it was done was kind of that they -- I didn't take a pager. So usually as an intern, you take a pager and you're on call for things. If something happens with the patient, the nurse pages you. I never took a pager. I had my personal pager, but that's different than like the service pager.

So I never took a pager. I wasn't on call. If any nurse or anybody wanted to communicate to the CV ICU team about a patient, that only rotated amongst the nurse practitioners. So if anything ever came up, it would have to flow to one of the nurse practitioners and then to me.

Q. Because of this supervision of one-to-three or one-to-two, was it the expectation that you would be in the ICU unit monitoring these patients?

A. No, because like I said, the -- at the

beginning of the rotation, Dr. Shake told me, you know, you round, the main expectations is for you to learn. Just go through and learn all this. We're not -- you're a first month intern, we're not going to be expecting you to be saving lives first thing. You're just in there to learn, and then when there's a lull you can go down to the operating room.

Q. I believe some of the nurse practitioners had made complaints that you were absent at times and they didn't know where you were. Have you heard those complaints?

A. I -- what I had heard was -- I mean, they knew that I was down in the operating room. What I heard was that they were -- they didn't voice this to me directly for a while, actually, but what I had heard is that they -- I don't know exactly who, I'm saying they, it could have just been Josh, but I know at least Josh was getting upset I was going to the operating room.

Q. That would Josh Sabins?

A. Sabins, yes.

Q. So if you're in the operating room, you're not operating, obviously, because you're a first month surgery intern?

A. No, you can scrub into cases. You can -- operating as in, like, my name wouldn't be the attending physician on it. But as an intern, you can operate from day one. It's a graduated -- it's graded responsibility. So an intern usually -- like sutures, somebody that closes, something like that. And then progressively toward the fifth year, maybe you're doing the operation.

Q. You weren't doing the operations, you were just observing when were you on the CV ICU rotation?

A. In general -- yeah, in general, that's correct.

Q. If an issue were to arise with one of your three patients while you off in the operating room, who would have handled that responsibility?

A. Like I said, the pager -- if something were to happen, the pager -- it would go -- if Josh and I and somebody else were on and Josh was carrying the pager, that information would go to Josh, and then he was -- I told him please text me or anything like that. The same thing that would have happened if I were, you know, not at my desk at the moment.

It's a very common thing in surgery where, you know, if you're down in the operating room, most of the time you can get paged directly, and then you've already handed your pager to the operating room nurse. And then if your pager goes off, she'll call back for you and let you know, and then you can go out and -- if there's an another attending there or something else that can take care of the operating things if you need to step away.

But during that time, it would have been handled by a nurse practitioner. If they needed my help or any questions asked, they could have texted me, called me. They had my phone number.

Q. I heard you say that Josh Sabins was getting upset or irritated that you were going down to the operating room.

A. That's right.

Q. I believe on July the 29th, that the two of you had an interaction that became heated. Tell me about that.

A. Yeah. So I guess to give you some context to that, if I remember correctly, he had said something about it beforehand -- before that day, maybe a week or so before, something like

that. And then I said, okay -- you know, it wasn't an argument anything like that, he just told me --

Q. Clear up just for the record. He had said something about what?

A. That I had been going down to the operating room, you know, that you need to be on the floor. It wasn't an argument or anything at that point, but I tried to approach Dr. Shake and let him know, hey, Dr. Shake, I know I'm the first one to go through this, but I'm hearing from you that I'm allowed to go down to the operating room. I'm hearing from -- and I even met with Dr. Shake about this, too. I'm hearing from you that I'm allowed to go down to the operating room, the nurse practitioner seems to think that I should be staying right there. I'm happy do either, but there's some miscommunications going on. It seems like there's no clarity here. Is it possible for to you kind of tell them whatever it is that you want me to do? If you want me to stay on the floor the whole time, I'll do it. If you want me to -- I'm okay, that's fine. He reiterated the goal for you is to learn, don't worry about that, is what he told me.

Q. Now, I know were you listening in to the deposition of Josh Sabins, correct?

A. No, that's not correct. I didn't hear that one.

Q. You didn't Zoom into that one?

A. No.

Q. He referred to a time where you were in the -- I'm going to ask this question first. Was there like a lounge or workroom where y'all would be putting stuff in the computers or a nurse station, the layout of the CV ICU?

A. Yeah. So there was a room -- you want the layout of it? It's basically like a -- I don't know, kind of like a C shape. You enter, it's kind of C shaped. Patient rooms all along, and then in the middle, middle-ish right here, there's a room where we kind of gathered. It's smaller than this. It's maybe like a 10-by-10 room with four computers, and the nurse practitioners and the resident would hang out in there.

Q. Mr. Sabins testified that y'all were in that room and Dr. Urencio was in that room, and he had expected you to -- the expectation was for you to be in the unit. And even Miguel had told you

that the expectation would be for you to be in the unit. Do you remember that conversation?

A. I do not. That would be unusual because, like I said, Miguel wasn't in charge of the CV ICU. He was a CT fellow, you know. So his responsibility was, you know, operations and taking care of patients, but he wasn't formerly involved in the -- in that ICU rotation.

Q. All right. Now, to -- that was before -- Josh Sabins' comments to you, that started a week before. Now, let's move into the 29th.

A. Okay.

Q. I believe the 29th was a Friday and would have been your last day in the unit?

A. If that's what you're saying. I don't recall. Yeah.

Q. Tell us about that. Did you work Saturdays and Sundays in that unit?

A. There were times that I did, yes.

Q. In that rotation?

A. Yes.

Q. Do you know if you worked the 30th and the 31st?

A. I don't.

Q. On the 29th, tell us what happened.

A. On the 29th, we rounded as we usually had in the morning, things like that. Naturally there's kind of a lull once all the orders were in, the notes were in. The procedures that needed to be done were done right around 1:00 or 2:00 generally.

So I told Josh, I said, Josh, I'm going down to the operating room, is there anything else that you need from me? But if not, you can reach me. And he said, you know, I told you before you're not to go down to the operating room. And I said, well, you know, I'm hearing from Dr. Shake that it's okay. Do we have anything else to do?

He said, no, but you're staying here. I'm your boss. And I said, that's not -- that's not what I've been hearing. Every time I've had to report, I report to Dr. Shake, and he's told me I can go down to the operating room.

And he's like, where's your shit? I'm going to take -- where's your shit? I said, Josh, why are you asking for that? He said, because I'm moving you and your shit out. And I told him, you know -- more forcefully than I'm going to do it now, but I told him, Josh, that's not happening.

You're not going to put your hands on me and you're not going to put your hands on my stuff. If you think you are, that's not happening. And then he immediately sat down, like, dude, dude, calm down, relax. That was really the extent of the conflict.

Q. I believe he testified that you pointed at him and said, don't you touch my shit.

A. I don't recall that. That seems inaccurate. I told him forcefully he's not going to be touching my person or my belongings. I was raised not to really put up with bullying, and I certainly wouldn't have escalated it to a physical altercation. I don't get physical with anybody. But if somebody is going to threaten me and my belongings, things like that, I'm certainly not going to allow that to happen.

Q. Did Dr. Earl talk to you about that incident?

A. He did. So in the meantime, once that occurred -- obviously it's highly irregular, very odd. I've never seen that happen at any point ever. So there was no chief resident on the service, it was just me and the nurse practitioners. So I went to a chief resident and

I told him about it.

Q. Who was that?

A. You know, I don't recall exactly who it was. There's an e-mail to the effect. I don't recall exactly who it was. There is an e-mail where he describes exactly what I told him and he sends it to Dr. Earl. And that's how Dr. Earl became aware of it because I told the chief resident who told Dr. Earl.

And I told him, you know, this is not normal. You know, this has happened because there's some sort of a miscommunication between what I should and shouldn't be doing. I tried to bring it to Dr. Shake's attention. Didn't seem to happen -- didn't seem to get clarified. And then Josh Sabins eventually got so angry he was basically threatening me. So I feel like I should raise an alarm to somebody.

And so he made Dr. Earl aware, and then at some point after the rotation ended, Dr. Earl called me into his office after hearing the story. He told me, listen, we need to de-escalate these things. I don't blame you for doing that. I've heard from people you didn't do anything wrong, but the goal is to de-escalate these. But if

someone is going to be in your face like that, I can't really tell you what you did was wrong, but try to avoid these situations in the future. And that was it.

Q. Who is Dr. Berger?

A. Ines Berger, she was a cardiovascular ICU attending. So she was an anesthesiology attending, but she rotated through sometimes on the CV ICU.

Q. So her and Dr. Shake were kind of over the CV ICU?

A. That's right.

Q. We've been going an hour.

(Off the record.)

Q. (By Mr. Whitfield) So your first rotation was CV ICU?

A. That's right.

Q. You rotated every month; is that correct?

A. That's right.

Q. So at the end of each rotation you get evaluations. And that's through the -- I believe it's called, at the time, E-value system?

A. There were a few, but E-value is one of them.

Q. Or E-hub -- I can't remember if it's Med Hub, then E-value, or E-value, then Med Hub.

A. Med Hub owns E-value. So it's all one thing, but E-value was one method. I think there was another one. A jumble of things. But yeah, E-value was one method to get evals.

Q. And you got evaluated through E-value?

A. That's right.

(Exhibit 6 marked for identification.)

Q. (By Mr. Whitfield) I'm going to hand you what's been marked Exhibit No. 6. What I've handed you is the master list of all the people that evaluated you at UMC, but it also lists the ones that you personally viewed yourself.

A. Right.

Q. Which the next to last column on the right, it gives a date and time that you viewed -- or the date that you viewed the evaluation?

A. Right.

Q. I'm going to start on the last page on Bates 38445.

A. The last page, 38445?

Q. Yes.

A. Do you mind if I take a second to look at this?

Q. Sure. So start on the back page. It says that Dr. Shake completed an evaluation for you on August 19th, 2016.

A. That's right.

Q. But you never checked it?

A. That's what it looks like. Yeah. I don't know that -- I think you might have to get -- they might have to get released to me for me to be able to see them, because I certainly would have been interested in every piece of feedback that I got. So I don't recall -- I don't know on the program's end how often or how I would see -- I'm looking at this for the VA, I think it's like that, I saw all of these.

But yeah, to the best of my recollection if I had seen -- I mean especially from the CV ICU, if I had seen an eval pop up in my e-mail as being viewable, I would have viewed it.

Q. But you would agree with me it shows that you didn't view this one?

A. That's correct.

Q. And the same for the evaluation of Dr. Berger?

A. That's correct.

Q. And they were the two attendings on CV

ICU?

A. That's correct.

Q. Going to the next page -- page 38444, I see that Dr. Giorgio Aru from cardiothoracic surgery compiled an evaluation for you on August 30th, and you viewed it on October 3rd?

A. Right.

Q. Dr. Cresswell did one September 1st, 2016, but you never viewed the one from Dr. Cresswell?

A. Yeah, according to this, I -- if I had access to it, if there was some way -- usually, the way that it would happen is, you get an e-mail saying you have a new eval for your viewing or something like that. So according to this report, it looks like I didn't see it.

Q. Dr. de Delva did one on September 3rd, but you viewed it on October 5th. So you waited a month to look at it?

A. That's what it looks like, yeah.

Q. It looks like you did not view the next four up, which would be from Anthony Panos, Jacob Moremen, Gretchen Shull, and Penny Vance?

A. Anthony Panos doesn't look like he completed one. That says open.

Q. Okay.

A. Jacob Moremen, Gretchen Shull, Penny Vance look like -- yeah, it looks like they completed theirs and I didn't get a chance to see them. That's correct.

Q. You saw the ones from Dr. Carroll, Dr. Vick -- Kenneth Vick, Barney Nicholson, and Rajesh Kuruba?

A. That is correct.

Q. Going to the next page, 38442, Shannon Orr completed one and you viewed it the same day, November 5th, 2016?

A. Yes.

Q. You did your self-evaluation, completed it on November 28th?

A. I see it right here, third row on 38442?

Q. Yes. Correct?

A. That's correct.

Q. And then John Harrison and Cheryl McCoy did one. Cheryl completed hers November 29th, 2016, and John Harrison December 12th, 2016, but you didn't view either one of those?

A. That's correct.

Q. On the next page, the ones that were completed were Shawn McKinney, Kenneth Vick,

Lonnie Frei, Larry Martin, and Shante Batson, Kelly Brister. The only one you didn't view was Kelly Brister's?

A. Right. That was completed on April 20th, 2017, which was three months after the day I worked and two months after my dismissal. To my knowledge, I didn't have access to that. So the e-mails go to my UMMC inbox, so I never would have gotten any sort of notification or anything like that even if it were released by that point.

Q. So the feedback that was given by these doctors that you didn't -- and the nurse practitioners, you didn't review those, the ones that say you didn't view them?

A. That's correct.

Q. Why would you not view it for those doctors?

A. I would have if I had seen it. So the only things I can think of is that -- I don't know how the program releases it. I don't know if they have to -- once something is complete, that they have to release it to me. I seem to remember that I would also have to complete an eval on that person for me to be able to see their eval of me, if I remember correctly. So maybe they hadn't

released the eval for them to me.

It could have gotten filtered out in e-mail spam filters, whatever that might be. I don't know. I was certainly interested. So whenever I saw one, I would view it as quickly as I could.

Q. Let's talk about your next rotation. What did you go to after CV ICU?

A. That would have been August of 2016, and that would have been CT surgery, cardiothoracic surgery.

Q. Who were the attendings on that service?

A. Giorgio Aru, Pierre de Delva, Jacob Moremen. I'm going to use the list I've got in front of me to cheat a little bit here. Going back to 38444. I mentioned Jacob Moremen. Anthony Panos was another one. Pierre de Delva I mentioned. Lawrence Cresswell and Giorgio Aru. I believe those are all. Let me check the last one. Yeah, I believe that's all of them.

Q. As far as nurses, would Penny Vance and Gretchen Shull been the nurses on those?

A. They were nurse practitioners, if I recall.

(Exhibit 7 marked for identification.)

Q. (By Mr. Whitfield) I'm going to hand you what has been marked as Exhibit 7. This is the comments from your evaluations. Have you seen these comments before?

A. I've seen them before. It's a little -- there's a different view of them. There's a different view of them that I think is probably a little bit more helpful where you can see exactly the numeric grade that you were given and the comments underneath. So it kind of corresponds, you got a two or a three or a five or whatever, here's the comment for that. But yes, I've seen these before.

Q. So let's walk through the ones from the CT surgery service, which you say would be Dr. Cresswell?

A. That's right.

Q. On September 1st, on the very first page of Exhibit 7. His first comment under Care for Diseases and Conditions was that you did a good job with initial evaluations with cardiac surgery patients both pre-surgery and post-surgery. Did you get that feedback or is this one of the ones that you didn't read?

A. I think it was one of the ones that I

didn't see, and I was not given this feedback verbally, no.

Q. Then under Care for Diseases and Conditions, Dr. Cresswell writes, "In my personal interactions with Joe, I have not seen problems in this area, but I have had several negative reports from other non-physician members of our team. In particular, heard reports of things that were deemed 'not my job' and incomplete follow-up with assigned tasks as well as general problems relating professionally to other non-physician team members."

A. Right. So, yeah, I've seen this through discovery, but I hadn't seen this -- I think it's a little troubling that this happens. Kind of a theme throughout some of the reviews of me is that, you know, he's saying I haven't seen any problems personally. He's an attending, but then he's getting reports from nurses or nurse practitioners, whoever they may be, of other things, and then giving me a lower grade or whatever as a result of what he's hearing from others instead of what he's personally observing. But, yes.

Q. Isn't that how the grading system works

in the rotation, that they take feedback from their team members to make a final evaluation of you?

A. I don't know exactly what the guidance is, but many of these is supposed to -- it's really helpful, I think, to get feedback from the attending because, you know -- for example, if one person were to dislike you, they can shift the opinions of everybody and all of your grades can drop. It's really helpful, I think, to get objective comments if possible. Or at least just the subject of opinion of the person who observed you, instead of being marred.

If there's something going on, that they're being told something that may or may not necessarily be true, it's certainly very prejudicial and it comes through in the comments. He's directly stating that kind of conflict. I haven't seen anything with them, but I'm being told something completely different.

Q. Going on to page 472 under the next core competency area under Surgery. Dr. Cresswell states, "I've seen only positive information exchanged between Joe and patients/families. I've heard reports, though, of interpersonal and

communication skills, generally, that were less than satisfactory."

A. That's right. I would say it's more of the same where he would have otherwise given me a great review, but here come the negative comments from others.

Q. Under Performance of Operations, he says he's had little opportunity to observe you in that area.

A. Right.

Q. Under Coordination of Care, he writes, "There have been issues with care coordination, particularly for the general thoracic surgery patients. Drs. de Delva and Moremen will be in a better position to offer specific comments."

A. Right.

Q. That's from him personally?

A. No. Care coordination, that seems like he's speaking directly to -- care coordination wouldn't have been something that he would have been privy to. That's something more administrative stuff, nurse practitioners and residents would have handled. That to me would have been something he's speaking about what he's heard from others.

Q. And then Improvement of Care, "I'm concerned that Joe did not respond well to the feedback from Dr. Earl regarding difficulties during his July rotation in the CICU, and some of these problems persisted during this rotation."

A. Right. The way I read that is, one, this is a separate rotation from the CV ICU. So he's hearing what happened on the CV ICU. Objectively, the only thing that happened on the CV ICU is the Josh Sabins' incident, and I think that's been a theme, you know, as I carry that Scarlet letter. Josh Sabins I think was liked. He had been there for a while, his wife is a nurse there. So the fact I had a conflict with him. And then also these people work -- the CT surgery people work very closely with Josh Sabins and, you know -- I think this carried forward.

And unfortunately, it just kind of marred the rest of my existence at UMMC. This comment is kind of -- events that -- what occurred in the CV ICU continued to haunt me and was brought forward. They're saying the difficulties. You know, I don't know what difficulties they are, other than what he's saying is just difficulties.

But, you know, the only thing that was

really identified to me as happening in the CV ICU was, one, that there was breakdown in communication. I was being told one thing by attending, another thing by the nurse practitioners. I tried to resolve that. It didn't get resolved, and it eventually ended in a conflict. I don't see that as necessarily communication errors on my end. I tried to fix that as much as I possibly could. I can't force the attending to say something to anybody.

Q. And then under Performance of Assignments and Administrative Tasks. Dr. Cresswell writes, "This is a mix of good and bad. On the good side, for instance, Joe prepared well for our monthly Journal Club and was an active participant. On the bad side, though, there have been problems with patient care follow-up as well as absence at assigned clinic activities."

A. Right. So again, the patient care follow-up, that seems like it would have to have been comments from nurses because he wouldn't have personally observed. So that's more kind of like administrative things that he would have -- that he's delegated, all attendings do. And I don't

know what he's referring to there.

Q. What about your "absence at assigned clinic activities?"

A. I was never absent, to my recollection, in any sort of assigned clinic activities. It was difficult with clinic because things get shifted around, things get moved. There were assigned clinic days, and sometimes they turned from a morning to an afternoon, or sometimes the first few cases would get canceled and you get to come in later or something like that. Or the last few patients would get canceled and you would get to leave sooner.

To the best of my recollection, I've never missed an assigned clinic activity.

Q. Then the other doctor on -- one of the other doctors on that service was Dr. de Delva?

A. That's right.

Q. You did review his comments?

A. Dr. de Delva's? Let's see. I don't recall, necessarily, because by this point I had seen them all. But yeah, it looks like I reviewed that on October 5th.

Q. So the feedback from Dr. de Delva was -- and we're going to continue these, because they're

broken down by core competency areas. We'll just kind of work through them. "Joe did a reasonable job in clinic, but failed to demonstrate that he owned the care of the inpatients. He often did not seem to have a finger on the pulse of the patient's situation. I often discovered issues and problems that I would have expected him to recognize."

A. Yeah, and, you know, this to me seems like it's -- like the attendings aren't intimately involved. They'll kind of dictate at a high level what the plan is, but, you know, how it gets carried out, things like that, is a delegated task. There's residents, nurse practitioners, things like that. He never brought anything like this up specifically.

This, again, seemed to be a case where nurse practitioners are communicating to him -- or somebody is communicating to him that I'm not doing something. I don't know what that is. I don't know what he's referring to, but he certainly never brought this up to me.

Q. But he did put it in your evaluation?

A. He did.

Q. That you were able to read?

A. Right. But, you know, the nature of the evaluations, you can see them, but, you know, what do you -- there's nothing you can do, you just read it. And you can't e-mail them, hey, this is wrong.

Q. Did you go back and talk to Dr. de Delva and say, what did I miss, what was I doing wrong?

A. No. There's sort of a cultural thing in surgery where, you know, I was kind of afraid to ask for, you know, specific feedback once they've already given it, or if they give it to me, I would ask in general. I would make that a practice to see how I could get better. But I'd been warned coming in that people can take things the wrong way and if you ask clarification, it can be seen as you questioning people.

So I was just, you know -- I'll take this feedback, I'm going to do the best that I possibly can to make sure that I coordinate everything in the best possible way and work with everybody as best I possibly can. But no, I didn't e-mail him. I didn't want him to think that I was, you know, questioning him in any way.

Q. Not so much questioning, but even asking for more details?

A. Yeah. That's a theme that comes out of this is always wanting more detail, but I thought that, okay, this is a negative review, I'm going to do my best. I'll take my best guess at what this is and try to improve from this point forward.

Q. Then he also comments that, "Several team members commented on failure to develop rapport and trust with nurses and nurse practitioners. At times he was seen as dismissive and above doing certain work. I did not see this personally, but heard back from team members. I'm afraid that if this is an ongoing issue, he will undermine his ability to be a good team leader as he rises in the program. He needs to develop some awareness and insight on how he is perceived by others."

A. Right. And I think this kind of goes back to that first comment that we just read. I think they're essentially the same one in that somehow I'm being perceived as not communicating well, and then that's kind of just inhibiting lots of patient care activities, coordination activities, things like that. I think culturally, I think the way that I speak and the way that I

handled myself --

For example, at a grocery store in the north, people get angry behind you if you're talking to a clerk and you're holding them up. They want to get out. They're like, hurry up, let's go, things like that. That's not the way here. So I was kind of learning how people kind of conduct themselves in the south. You take the time, you say hello, and you talk for a little bit. Things move slower, you -- you know, take the time to talk to people, really. You know, I had just been used to kind of go and you're polite, you're not necessarily taking the time to sit down and talk to people and things like that.

So I think in terms of the perception of me, I think the cultural issue probably played a role in that. But, you know, to the best of my recollection, there was never a time with Penny Vance or with Gretchen Shull that I was ever rude, condescending, anything like that. I think a lot of it was the cultural thing. And then also, carrying forward from the reputation that I had in after CV ICU with the Josh Sabins' incident.

Q. When you say a cultural thing, I want to drill into that a little bit. You're talking

about north versus south, high-speed environment versus laid-back environment; is that what you're referring to about cultural differences?

A. That's right. Just kind of like the nature of the differences between someone from, say, Chicago, New York, something like that, that's definitely a northern fast-paced environment versus the south where people take the time, they talk to each other, things like that.

Q. I want to make sure. In this lawsuit you make law claims about being treated differently for being Hispanic. When you say cultural, you're not referring to the Hispanic culture?

A. No. That's correct.

Q. Then Dr. de Delva --

A. Are we on 472 now?

Q. Getting there.

A. Okay.

Q. He gave you positive feedback that, "On the limited interactions we had in the OR, he did well." Under Performance of Operations and procedures on 472.

A. Okay. Let me catch up with you. Okay. Yeah. And this is one, you know -- I just like to

kind of note that this is one where there are no nurse practitioners in the operating room, things like that. So this is entirely his own experience. So when he worked with me on his own and nobody else had commented, I got a good review it looks like -- it looks to me. That was pretty good.

Q. Back to the first one. He states -- this is on 471. "I often discovered issues and problems that I would have expected him to recognize." He's talking about his own personal observation?

A. Yeah, I can't comment on what exactly he means, because there was certainly nothing brought up to me. But what I would guess is that he's discovering issues that are brought up to him by nurses. By nurses, I mean nurse practitioners. Sorry.

Q. I would assume they get really offended for a nurse practitioner to be referred to as just nurses?

A. I don't know, but they've gone on, they've earned the degree and things like that, so I give them their due. And it's also, you know, they're different.

Q. Then on 473, he refers back to, again, the feedback from non-physician team members. "Joe appears burdened to interact with them and take into consideration their opinion and experience."

A. 473, I'm trying to find where you are.

Q. Third one from the bottom.

A. Okay. Yeah, I mean, again, I was never -- I always had the attitude, if you will, that by this point I'm two months in -- by the end of this point I was two months into my residency. I had the opinion that I could learn from everybody, everybody had something to teach me, whether you're a nurse, nurse practitioner, whoever, resident, attending. These people are much more experienced than I am in the -- just at least in the day-to-day flow of everything, understanding how to take care of these patients specifically.

So I don't understand where I would have seemed burdened to interact with them and take into consideration the opinions and experience of others. I think that might speak to that kind of cultural difference where maybe I was coming off as just kind of short or something like that,

because I'm from -- I spent time in Michigan, I'm from Florida, which is technically geographically the south, but not at all the south really. So I think that was a large part of where this is coming from. But other than that, I can't think of a single time where I had a negative interaction with any of them.

Q. What I'm hearing you say is it's because of your fast-paced lifestyle before living in Michigan and Florida is that you came off as rude and short with people?

A. That's my best guess. I don't think I -- I didn't personally -- this is obviously an issue with -- I never intended for it to happen. I didn't personally think that I was. But if someone is perceiving you a certain way, then there's obviously a reason for it. And that's what I'm thinking it is, it's a cultural issue. I probably didn't take the time to get to know them enough or whatever. Whatever it is that I was missing, I just was missing that part of it. It wasn't that I was intentionally trying to be rude or I was just rude. I think it's just we grew up in different environments and I was still learning the Mississippi ways, I guess.

(Exhibit 8 marked for identification.)

Q. (By Mr. Whitfield) I've handed you what's been marked as Exhibit No. 8, which is an e-mail from Dr. Berger to Dr. Earl, and an e-mail from Dr. Shake to Dr. Earl on the back page. This was provided to you in discovery and was an exhibit at the academic appeal hearing. Have you seen this document?

A. I have.

Q. I want to kind of go through. So Dr. Berger you said was the other attending on the CV ICU rotation, which would have been your very first rotation?

A. That's correct. There was one more, at least, attending. But yeah, she was one of them.

Q. She reported directly to Dr. Earl about some concerns and issues with you on the rotation. That's the gist of this e-mail. The first concern is she talked about how you liked to go to the OR after rounds to learn more about surgeries, "and the nurse practitioners asked him to pull a chest tube or teach him how to wire an A line or pull a balloon pump up while he wants to go to the OR. The perception of the nurse practitioner was he is arrogant, like, 'you're not my boss, I'm a

surgeon,' when I ask him to help or want to teach. As he does not check in with them, they assume he is gone or does not want to help until he comes back from p.m. rounds." Do you see that?

A. I do.

Q. Do you remember incidents where they asked you about to help them with an A-line or a balloon pump but you just wanted go to the OR?

A. No, there was never a time -- I don't know who said that, but there was never a time where I would have refused any task -- to my recollection, that I ever refused a task or told them I'm going down to the operating room. I'm just going to go down to the operating room and not do this task.

Q. What about statements, "you're not my boss, I'm a surgeon." Have you ever said that to the nurse practitioners?

A. No, not that directly. But when Josh, that exchange -- I think you said it was on July 29th. The fact that this e-mail is on July 29th makes me think that that wasn't -- yeah, I did talk to Joe this afternoon. So that makes me think that July 29th was not the date of the incident with Josh Sabins. Regardless, it would

have been pretty close to that.

Q. Let me stop you. Look at No. 3.

A. Yeah. I don't know. It could have been that day. I don't think I spoke to Dr. Berger on the exact same day that it happened. I do remember speaking to a chief resident.

But yeah, going back to your question, "you are not my boss, I am a surgeon." I never said that in regards to a task. The only time that I said some variation of that is when Josh was telling me, no, I'm your boss, you don't listen to Dr. Shake, you stay here and you're not going down to the operating room. I said something like, Dr. Shake is the one that I report to.

But this seems to be -- I don't consider that an arrogant statement. I thought, you know, he's telling me this is how it's going to go and he was already starting to get heated, things like that. And I said, the person I report to is Dr. Shake.

Q. He says this in kind of the plural, the nurse practitioners asked you to help with something. Why are they reporting that you're not? Why would you believe they're saying you're

not willing to help?

A. I don't know. I wasn't privy to this conversation. There was never a point when anyone brought this to my attention. So, you know, I don't know why they would say that.

Q. But as you see the paper, it was -- you definitely see it was reported to Dr. Earl that this is what had happened?

A. Yeah. I mean, that looks like what's coming from Dr. Berger.

Q. He talks about an incident where you took coffee into a patient's room and there was -- tell me about that.

A. Yeah. So it seems to be a lot of confusion about this. So No. 2 is that I brought coffee into a patient's room. If I remember correctly, this was day three of residency overall, or maybe day two, something like that. I walked into a patient's room, I didn't notice that all of the other providers had coffee but they would put it on like the handrail outside of the patient's room before they walked in. So I walked in with it. I was in there listening to rounds, and somebody, I guess it was Dawn, just kind of yelled out in an angry way, but yelled to me, hey,

you can't bring coffee into a patient's room. Oh, sorry. I walked out, put it on the handrail where everybody else did, and that was the end of it.

Q. But that was day two or three?

A. Right.

Q. Then in No. 3 Dr. Berger refers to the argument between you and Josh Sabins?

A. That's correct, which happened much, much later.

Q. And then Dr. Berger talks about how she had a talk with you. What do you remember of your conversation with Dr. Berger? She states that you talked about perception, that it appears things have gone in the wrong direction, the role of the nurse practitioners, how to set yourself up for success as an intern and expectation of the surgical team. We talked about the food/coffee in the rooms.

This is her recollection of the conversation. What is your conversation?

A. As I'm reading this now, this all looks correct to me. I don't remember anything more or anything less of the conversation than what she's kind of outlined. At a high level -- she's one of the only people that come to me as a mentor. It

seemed like she was genuine, trying to give me advice and understanding when she heard the story of what happened and how to avoid things like this, and just kind of how to proceed going forward to ensure success.

Q. You did get an almost immediate feedback from her that day?

A. Yeah. Her feedback -- once she heard the story -- and you can kind of see the evolution of the story just in this e-mail chain. Because on page 2, Papin 439, the bottom is her initial e-mail to Dr. Shake. Then Dr. Shake later in time. Then Dr. Earl is e-mailing back her and Dr. Shake.

You know, I think once the story evolved and she understood what exactly happened, she wasn't necessarily blaming me for what happened; she was giving me strategies for how to avoid having this situation even occur from the beginning.

Q. And then in her first e-mail from 12:51 that day, Dr. Berger talks about that you've had falling outs with all four CV ICU nurse practitioners this week. There's also been issues with the pharmacists. Did y'all discuss that in

your meeting?

A. No, that's inaccurate. That was her initial e-mail. I assume she had spoken to someone who had given her inaccurate information. In my life, I have never had a dispute with a pharmacist. I certainly don't recall having fallouts, at least on my end -- I mean, perception is different, but I've never had a fallout -- I didn't have a fallout with all four CV ICU nurse practitioners that week. To the best of my recollection, it was just Josh. Certainly. That was the only one where there was a discussion.

Q. Now, we're kind of going back to Dr. de Delva and his evaluation of you. I'm on page 475.

A. All right.

Q. It should be the fifth comment down. It says, "Joe seems to be a good person and capable of being a good resident. I think there is a disconnect between the wanting to be a surgeon and understanding the path to get there. I hope he is just -- I think he is having difficultly adjusting to the reality of residency training and entering the clinical environment. I hope he will take the feedback given in this rotation constructively.

Otherwise, I can envision him becoming increasingly frustrated and marginalized by those he will need to be successful in training."

You got that feedback?

A. I did see this, yes.

Q. The other attending on that was Dr. Moremen, I believe you said?

A. Yeah, one of them -- and I think they're -- Dr. Aru is also the other one. So it's Moremen and Aru left that gave comments.

Q. But you never read Dr. Moremen's comments?

A. Yeah, that looks to be correct from this, but they did produce comments is what I was saying.

Q. So the first comment from Dr. Moremen is on page 471, "Seen as frequently avoiding duties, not present and accounted for during regular hours."

Do you see that one?

A. I do.

Q. So he's giving feedback here saying we're not seeing you, you're not present. What are you going do to fix those types of feedback issues?

A. I mean, I didn't see this comment, but I don't know -- this absolutely would have been something that was reported to him and not something that he's -- the attendings don't stand around, you know, he's got operations to do, things like that. That absolutely would have been something that was reported to him. I don't know what not present and accounted for during regular hours were. I was there. There might be an issue where as a resident you can go down to the resident room and type notes, you can do that type of thing. Any open computer you can go.

So there's not necessarily an area you need to be. So I don't know how anyone would be able to reasonably comment on anyone's position at any given time in a hospital because you're not expected to be in any one place if there's nothing going on.

Q. When you're on a rotation, do you have like an assigned area that you deal with?

A. Assigned meaning clinically where the patients are located?

Q. Yes.

A. The CV ICU certainly, yes, we were all on the CV ICU. But I would say other than that,

patients could be spread pretty much anywhere around the hospital.

Q. And did you have -- like when you're on the CT surgery rotation in August, do you have a pager?

A. I do.

Q. But the nurses and Dr. Moremen are apparently reporting that they can't find you.

A. Yeah, I mean, you know, that wasn't brought up to me for a very long time. I can't recall. Probably around December-ish it was brought up to me that that was even a concern or anything. But yeah, evidently from right there, I guess that was a concern.

Q. Then on top of page 472, Dr. Moremen cites that you're an abysmal communicator, complaints numerous.

A. I mean, you know, I don't know the context of that, you know, complaints numerous. There's nothing actionable from that. Where I was -- I brought this up to Dr. Earl because in one of our meetings, I think in -- I believe it was after clinical competency, the semi-annual review, I got the same comment. And he would just say you need to work on communication.

I feel like -- not to be flipped or anything, but I feel like he's speaking English on communicating with people. I don't understand where this breakdown in communication is happening. Again, I don't really understand the genesis of this. I would have been happy to improve in any way if I was told anything specific, but I really don't know where I was not communicating.

Q. Then on page 474, Dr. Moremen states that, "He seems almost never to be prepared or recall facts from previous discussions." This would have been your interactions with him.

A. Yeah, you know, to that, I would -- that seems to be commenting on my intelligence or preparation. I was there; I had the information. I'll say that in terms of my ability to recall facts, intelligence, things like that, that's never really been called into question by anybody up until something like that. So I would hardily dispute that.

Q. This would have been more, I assume, your preparation for the patients and not being able to recall the facts of that particular patient?

A. Right. Generally, you know, I read something once and I can recall what the information is, and I would have -- you know, anytime you're rounding, I would have already pre-rounded on the patients, known who they were, known the pertinent facts and things like that.

So, again, this is obviously negative feedback here. Seemed to be prepared or recall facts from previous discussions but -- seems almost never prepared. When was I never prepared? When was I not able to recall facts? I can't take any sort of action from that, and I would dispute the basis of it.

Q. But you would agree with me that's coming from the attending physician?

A. I would.

Q. Next one for him is also on 474, "Had to be reoriented to miss details almost daily."

A. Yeah. Again, you know, this is coming from the -- this is written by the attending. I think he might be misappropriating his own observations or mislabeling -- he's not necessarily saying I personally observed this, but he's also not saying that this was told to me by nurse practitioners or anything like that.

I don't really need re-orientation. I don't really miss details that often, to my recollection ever, but, you know, this -- another piece of negative feedback that I have no idea where it was coming from.

Q. There were also two nurse practitioners on the service, Gretchen Shull and Penny Vance.

A. That's correct.

Q. And you didn't read their reviews either?

A. I think reading is a mischaracterization of it. I think that tends to imply that I had access. If I had seen and been able to access it, I would have clicked into it immediately. I think everyone is curious, you know, what people are saying about them. I wouldn't have avoided looking at these reviews.

Q. Doesn't the system work that once it's complete, the system sends you an e-mail saying, hey, you can check on this?

A. I don't know. All I know is, on my end, I would get an e-mail that would pop up and say this is ready for your review or whatever it is, some variation of that. I don't know what it took for that to actually pop up or who had to enable

that or whatever, I don't know. But I do know I was always really curious about feedback and what people are saying and things like that. Because it has implications, too, for not just, you know, I'd like to know how I did, but had I been able to continue, this has implications for promotion to the next year, things like that.

Q. Before I get into the nurse practitioner, we've been going just over an hour again. I'll give you a quick break.

(Off the record.)

(Exhibit 9 marked for identification.)

Q. (By Mr. Whitfield) I've handed you what's been marked as Exhibit No. 9. It's an e-mail to you letting you know that there was an evaluation completed on August 31st, 2016. Is this how you would be notified that one of your evaluations had come in?

A. That's correct.

Q. So this generates -- when the person completes it, you get a link saying it's complete, you can view the evaluation?

A. I don't know the exact process. Like I said, I don't know if they complete it, it auto generates or if they completed it and it has to go

through Renee and then be sent to me. That I don't know. But this is what it looked like once I -- in the end once I finally got it, this is what it would look like.

Q. The one that was completed on August 31st would have been Jacob Moremen's?

A. That looks right. There are no others that were completed on August 31st. So that looks right.

Q. So once you got those e-mails, you just click on the link and it takes you to the evaluation?

A. No. So you have to complete your evaluation of them and then I think you're able to view it. It says that right there under the link kind of in the middle of the page there. And I don't recall how long it would take for it to register that you put yours in for you to be able to view theirs and stuff like that. Or if it was getting caught by my spam filter or whatever that was. Because these are kind of spammy e-mails. It looks like something that a spam filter would detect and drop for you. But I did see these from time to time.

Q. To see it, you would have to go in and

complete your own evaluation?

A. That's right.

Q. Why would you have not gone in and completed the one for Dr. Moremen so you can see this evaluation?

A. The only reason I wouldn't -- it wouldn't have been willful. It wouldn't have been I don't want to see what Jacob Moremen has to say about me. It would have been I didn't see this e-mail letting me know.

Q. At this point you're aware that your professors are assigned to do evals at the end of the rotations?

A. Right. Yes.

Q. If you wanted to know what Dr. Moremen had said, you would have gone in and filled it out?

A. Well, I wouldn't have known. So if I didn't see this e-mail, I wouldn't have known that Dr. Moremen -- because evals can come in at any point, so I wouldn't have known that one was done without any sort of -- I just relied on the notifications. If I got one, I got one, and then I would go in and pull up the eval and look at it. And if I didn't, I would have just assumed it

hadn't been done yet.

Q. You definitely got the e-mail to your system. Now, whether you opened it or not is a different story.

A. Yeah. This looks like it came to my e-mail. I'm assuming this is my UMMC in box?

Q. Yes.

A. Yeah, it looks like it did, but, you know, whether I'm viewing it on my phone or whatever, there's different spam filters that kind of move them around so you don't -- I don't know if I ever saw this e-mail or if I just missed it. Had I seen it, I would have clicked it and completed the eval and been curious what he had to say.

Q. Then with the nurse practitioner Gretchen Shull, she gave you one as well on October 3rd?

A. That is correct, based on 38444.

Q. And she cited under Care for Diseases, "Basic skill and knowledge for patient care was lacking."

A. She did. I dispute that. I don't know what basics skill and knowledge for patient care is describing. But the eval exists. I don't

think that -- I don't at all agree that I lacked basic skill or knowledge about patient care.

Q. She goes on to say under the next one down in Care for Diseases, "I found him to be disrespectful to nurses and female support staff. I didn't appreciate when he would talk to me with his back turned."

A. Yeah, I'm sorry that she -- that she ever felt disrespected by me in any way. Again, I disagree with this. The eval certainly exists. I disagree with it. You know, talking with your back turned, I don't recall that specific instance. I'm thinking probably I was talking to her and the initiating conversation, I turned around to type on the computer or something like that or whatever. It was not meant to be any sort of a shunning maneuver or anything.

So, you know -- I think this is probably part of that kind of that cultural difference where, you know, if someone is talking to me and they turn and they type on their computer or something like that, I don't consider that rude in any way. But to some it may and I just wasn't noticing that.

Q. I'm going to talk about Penny Vance as

well because she was also a nurse practitioner on that service. So as we go through, to save time, I'm going to take their comments. Penny did hers on September 16th.

A. Okay.

Q. Her first comment is under Performance of Operations and Procedures. "Rotation goal at PGY1/intern level was to learn surgical care (CT specialty) in participating in clinic seeing patients and rounding on floor with patients and proper documentation. Goal at this time was not specifically to participate in surgical procedures, although intern could if he/she had time once his other responsibilities were completed. Was, however, observed with a higher level resident in placing a sterile dressing post sterile procedure on a patient, and observed with a higher level resident in placing a sterile dressing post sterile procedure on a patient, and observer (Nurse educator for unit) offered to teach intern how to properly apply sterile dressing using sterile technique. The nurse educator reported intern repled that he didn't need to know how to do that."

That's pretty specific feedback.

A. Yeah. A few things on that. If you'll notice at the top of this, "Surgery: Performance of Operations and Procedures." The heading on this is, "Resident demonstrates knowledge of operative procedures" -- which is specifically referring to the operating room. "Technical skill," also an operating room thing. "Tissue handling," also an operating room. "And proficiency with instrumentation," also only in the operating room appropriate for that level of experience.

So my first comment on this, she really should have abstained from writing an eval on anything to do with the operating room because they're just not in the operating room, ever. So this is another one of the things where she's rating me. And I remember this specifically because I saw this in discovery, I get a low rating on something that they don't really -- it's not within their purview to be able to assess.

And then commenting on this specifically, I don't -- I dispute basically all of this. "The goal at this time was not specifically to participate in surgical procedures." And in the title of the rotation is

cardiothoracic surgery. As an intern, you want to learn how to manage a patient, you want to learn how to take care of patients first. That's always what you want. And then you also learn surgery at the same time. That wasn't how it was presented to me, that surgery was like, if you've got some time, figure it out. You're in surgical residency to learn to be a surgeon.

And then, you know, putting on a sterile -- I don't recall this. This is something that I would do multiple times daily. This is something that you learn as a third-year medical student. It's something that's so -- you know, for an attorney, it would be like learning how to turn on a computer or something like that. It's something so critical and so commonplace.

I mean, putting on a dressing sterilely is something that's, you know, very easy to do and taught very early. So yes, I know how to put on a sterile dressing. I don't recall ever having to be corrected or telling a nurse educator or even having a nurse educator come up to me. I didn't need to know how to do that. I don't know what a nurse educator is.

Q. You just don't recall the incident or it

didn't happen?

A. I mean, I don't recall the incident at all. I don't want to say necessarily that it didn't happen, if someone came up and I just don't recall that I was doing a sterile dressing. But I mean, placing a sterile dressing is something that's done by any surgical resident multiple, multiple, multiple times per day. I certainly don't recall this in any way.

And then, "At the end of it, nurse educator reported that he didn't need to know how to do that." First of all, putting a sterile dressing is, like I said, so fundamental that I do need to know how to do that. And I don't know what a nurse educator is. If that's like a nurse who's educating me at that point or is that like a formal title, like a nurse professor. I don't know.

Q. The next one from Penny Vance, "Did not personally observe intern in OR, as this was not the goal of this rotation (as a PGY2 his focus on CT surgery rotation will purely be to participate in surgical procedures and complete consults.) I did instruct on procedure and was present, and he did follow instructions well in this instance.

However, in several instances was instructed by myself and fellow to perform a procedure (after I signed out for the day) and he failed to perform the procedure as ordered by the attending, so it did not get done.

Also, I offered to show him how to perform the procedure and he walked off, stating he would ask the fellow if he needed to this. I spoke with fellow and he advised that he directed him to perform the procedure (was a twice daily medication dosing via chest tube, and I had performed the a.m., and the p.m. procedure fell at a time after I leave in the afternoon.)"

What do you remember about that chest tube procedure?

A. Nothing whatsoever. I don't recall this situation. I would characterize this as inaccurate because I don't ever recall this happening. Should something like this had occurred, I would assume that the fellow would have brought it up himself. No, I don't recall this ever occurring.

Q. Once again, it didn't happen or you don't recall this occurring?

A. I don't recall this ever occurring. To

my recollection, there was never a time when I was asked to do something and I didn't do it. That's the first thing. And then second, that I was asked to do a task and refused to do it. It kind of falls under both of those.

Again, this is another instance where Penny Vance, who is a nurse practitioner, is commenting under performance of operations and procedures. "The resident communicates effectively, efficiently and professionally in the operating room." Nothing about what she's referring to. She states it herself, she knows that this is supposed to be in the operating room, yet still comments and gives me a low grade.

Q. She's also commenting about -- you're not denying that she's commenting about specific instances of conduct with you? I know you dispute whether they're accurate or not, but she's telling UMC and you in your feedback that you walked off and didn't do this procedure and said, I'll ask the fellow. She tells that in her statement, right?

A. If you're asking --

Q. Those are the words on the page?

A. Yeah, the words on the page are that. I

mean, I don't -- I didn't see this eval, and it obviously wasn't mandatory for me to have seen this. There was no sort of like catch -- if this was supposed to be like, hey, you're supposed to be absolutely seeing these all the time, this is your main method for getting feedback. I mean, generally having gone through the MBA program, things like that, taught about how to manage people. You should tell -- if you're not doing something that you should be doing, you should tell people directly and not put it into some sort of an eval. That's not necessarily -- things can get lost, things happen.

So, yes, they're in here. I dispute that they occurred. And, you know, I never saw this until discovery.

Q. Then Coordination of Care, still on Penny Vance, "Did not communicate with CT team well. Was advised first day of rotation what his responsibilities were by attending staff, and did not report to cardiac surgery clinic on days responsible, as well as on multiple occasions asking another team member to perform his duties that he did not want to perform."

A. Yes, these statements are inaccurate. I

would ask if you're telling me -- that's a pretty serious allegation to me, that I'm not showing up on days responsible. It's pretty easy to verify in the medical record when was clinic, did Joe write any notes from that clinic, because I would have written notes and things like that. You can go to the medical record, tell me which patients were there, and we can go to the medical record and pull that up.

And that's what I would love to happen, because, I mean, at least this is verifiable, you know, like that -- whether a procedure at a patient's room occurred or didn't occur, whatever, we don't necessarily document every single thing like that. This would be in the medical record. So I would hope that we could check that.

Q. Same category under Coordination of Care, this is Gretchen Shull. "Poor communicator to the team about patient plans."

A. Yes. Gretchen Shull says that. Again, this isn't specific in any way. I don't know what a poor communicator to the team about patient plans is. I would have loved to have gotten better, but we all rounded together, everybody knew -- the plans were formulated -- it comes from

the attending. I'm not making a plan on my own and coming off with how we're doing things.

So they come from the attending, we're all rounding together with the attending. Whatever would get communicated is whether something was done or something like that. But, you know, I would always communicate to them, you know, oh, this that was asked for by the attending is done, to the best of my recollection. So I don't know what this is or how I could have gotten better from it, or how anyone could get better from it.

Q. And then Gretchen Shull under Improvement of Care, "Poor insight into own behavior."

A. Yeah. I mean, that to me -- I dispute this. I'm very introspective, I'm very reflective. This seems to me to imply -- when I'm reading this, it seems to imply that she did any sort of redirection or try to speak to me about my behavior. That certainly was not the case. She never spoke to me and said this behavior what you're having, it's wrong or, you know, it's misdirected or whatever it is. We never had the conversation. I don't know where she's even

basing this off of. This seems like something she's just inferred.

Q. Then top of 474, back to Gretchen Shull. "Would be late to clinic or not show entirely, and even sometimes just disappear."

A. I dispute this, too. Late to clinic -- I mean, there were reasons to be late to clinic. So clinic would occur -- I would have floor patients and things like that, things going on, you can get a page where something is going on with a patient, I have to show up to that, I have to be there because I'm the first call as the intern. So if something were to happen, sure, I could be late to clinic. I can't possibly pretend that I was always on time to clinic, but there would be a reason for it. It wasn't just that, you know, I decided to play tiddlywinks or something.

If I were late, I was doing something to do with patient care at the hospital. And then clinics where you have to drive, you know, through traffic, who knows, whatever, you have to leave campus and drive over to clinic. But no, there was never a time that I recall ever that I just didn't show up entirely.

There were times sometimes when I would get a text from one of the nurses in charge and saying like, oh, there's just one patient here, you don't need to come in, something like that, but there was never a time where I was expected to show up, that I recall, and didn't show up.

Q. Do you have any of those text messages?

A. I can check. It might have just been a page, too. It's some sort of communication, e-mail, text, something, where they say there's only one patient, or this is canceled for the day, something like that.

MR. WHITFIELD: Y'all look and review and produce any of those that you may have.

MR. MORGAN: Sure.

Q. (By Mr. Whitfield) Bottom of 474, Gretchen Shull, "Did not follow instructions regarding communicating discharges and follow-up instructions to our team."

A. I don't know what she means here. Because discharges, that can certainly be communicated to our team, but that's usually something that's communicated to -- you know, we know it's happening. That's something that's usually communicated to the patient. Follow-up

instructions is something that's exclusively communicated to the patient and generated by our team. So I don't really know what she means here.

I get the general theme is that, you know, somehow I'm not communicating things. Again, I don't know -- there's no specificity to this, there's no which patients did I not communicate a discharge to or about or whatever. This may be meaning to mean -- I don't know. To my recollection, there was never a time where I didn't communicate a discharge or give follow-up instructions to the team. And moreover, when you write out a discharge, it gets printed out and given to the patient. You have to have instructions there. Follow up, come back in six weeks. If you have fever, chills, nausea, vomiting, something like that, call 911 or call this office number or something like that.

Q. Then on 475, it's under the Performance of Assignment and Administrative Task column. Penny Vance states, "Very disappointed with this intern's performance on CT surgery rotation. Would expect an intern being accepted to our general surgery residency to be the cream of the crop as is very competitive. On a positive note,

his documentation was actually better than expected for an intern."

Do you dispute that your documentations were better than expected for an intern?

A. To be honest, I didn't read everybody else's documentation, but I will gladly take one glimmer of hope from that. It kind of seems to go in counter to everything else. Documentation is a form of communication if I'm able to document -- if I'm able to keep it straight for documentation. If I'm able to keep everything correct for documentation, the plan, the history, the orders, everything like that, all the stuff that actually -- we gain -- we document -- all the information we obtain, we document. If I'm able to do that, I don't know how I'm being characterized as not communicating, as not knowing anything. I don't know. This is only my second month of residency, too.

Q. Gretchen follows that with, "He has set the bar quite low for the general surgery residency here at UMC. He seems to be unteachable and lacks a general awareness of professionalism. He lacked an understanding of basic care, but refused to admit his shortcomings. Was

consistently playing the blame game when he was approached. It was a bad experience to work along side him."

A. I dispute -- I dispute this evaluation. I mean, it seems, you know, pretty biding, I would say, is the tone of this. There was never a time where her and I ever spoke, there was never a time where her and I had any sort of interaction that was negative. I can't comment on what she thinks is professional and what's not, but lacking an understanding of basic care -- she never brought up shortcomings to me. So I don't know how she can say that I refused to admit shortcomings.

"Lacked an understanding of basic care." That's not true. And was consistently playing the blame game when he was approached. Again, never approached during the rotation. So I don't know when I would have played a blame game or anything. This is the first time that I've seen, you know -- this is like the final comment, I would assume? This is like the overall kind of thing, I would think?

Q. It seems so.

A. Yeah, so blame game -- who am I blaming? There's no one else to blame. It's me or the

nurse practitioners. I don't know who I would have blamed. It would have been her if we were working together. She doesn't seem to be saying that I'm blaming her. I don't understand. I basically dispute everything on this.

Q. But you do not dispute that these are the words on the page that were reported in your evaluation?

A. That's correct.

Q. So now, this is through your second rotation. So you've had CV ICU as your first rotation and CT -- cardiothoracic surgery as your second rotation?

A. That's correct.

Q. So if we're logging a tally here, we've got reports that had a falling out with the nurse practitioners and the pharmacist in the first rotation, your incident with Josh in the first rotation, and then it carries over. Now we've had three attendings that have given you negative comments and the two nurse practitioners in your second rotation that have given you negative comments.

A. No, I don't think that's the case. Going back through your walk-through, I think

we're talking about Exhibit 8 here. Dr. Berger was mistaken when she said four CV ICUs. Not necessarily that she had misinterpreted, I think she had been given inaccurate information. Then as these e-mails evolve, in her final summary where she seems much more, you know, abreast of the situation, she's not talking about how I've had fallout with all the NPs. She's now narrowed it down to just Josh Sabins. So no, I did not have fallouts with all the nurse practitioners, it was just Josh Sabins. I've got a text message with him, you know, the next day telling me, hey, are we cool? We don't need to report this. I don't remember the exact characterization if it, but it was basically saying, like, are we cool? We don't need to report this, something to that effect. I've got that text message.

So I didn't really have a fallout with Josh. I thought -- he told me the next day, you know, I've been to anger management three times, I have a temper if things can go wrong. I'm like, hey, man, it's cool. Everybody -- you know, whatever, it's fine. I'm fine with it if you are. By that time I had already reported it to the chief resident.

Q. These are the text messages you produced to us already?

A. I'm not 100 percent sure with Josh because they haven't come up necessarily. I don't know if the Josh Sabins' text has been produced, but we certainly can.

Q. Is this the one where he said I didn't tell Dr. Berger?

A. That sounds like it -- that sounds like part of it. Yeah, that would have been the text, or one of them, yeah.

And then you went through and you were saying -- other than that, you'll notice the -- on the CV ICU, Dr. Berger and Dr. Shakes, their numerical evals -- which aren't in this, these are just comments. Their numerical evals of me were good. Dr. Shake and Dr. Berger were both, as far as I recall, the two ICU attendings from that first month that reviewed me. Those were good.

Then the CT surgery, I mean, the CT surgery attendings, residents -- not residents -- attendings, nurse practitioners, nurses, they're all -- they're very close in time. It's almost like two of the same months. I transitioned from the -- instead of being in the ICU, I was now on

the floor. Usually when they come from -- when they're on the floor, they've come from the ICU. So these people work together all the time. You can kind of see how this information can kind of flow from Josh or whatever that I might be a jerk or whatever, I have this Scarlet letter already, very closely linked.

Then you have people like Dr. Cresswell, things like that. Even Dr. de Delva -- everything I saw of him was good, but I've heard this. So, no, I wouldn't characterize those as like negative evaluations from the attendings. They were outlining what they had heard.

But, you know, there seems to be a rift between nurse practitioners, Gretchen Shull and Penny Vance, and that's inclusive of, you know, commenting on things that they really shouldn't be, where I'm getting obviously terrible evaluations from them, and then, you know, the attendings who largely are saying I'm good from what they've seen.

Q. They also had things in theirs that you had to be reoriented to details, having issues keeping up with the pulse of the patient in their evaluations.

A. Right, which I think -- what I'm -- yes, those were -- I'm not agreeing with that. I'm saying that those were in the evaluations themselves. I suspect that that's from the nurses, the nurse practitioners. Because, you know, like Earl has said it himself, lots and lots of people, I'm intelligent, you know. Keeping details together has never really been an issue for me in terms of remembering patient details, being prepared. That's something that I pride myself in is my preparation coming in and knowing things about patients, just in general being knowledgable.

So I don't think that they ever observed that themselves. I think that was something that they were told and they were, you know, reporting, or they were told it and it, you know, clouds or colors your view of the world from that point forward.

Q. Now, you commented on Dr. Berger's first e-mail being that she got more detail later. Did you talk to Dr. Berger about that or is that just something you're supposing here on the spot?

A. Well, we had met at this point, and then we all met, all being Marita, myself, Josh Sabins,

and Dr. Berger and all met. It was at this point that she made the e-mail. She never brought anything up to me about having a fallout with all CV ICU nurse practitioners. This is just me assuming because she never brought it up to me. It was just the Josh Sabins issue.

The pharmacist thing, absolutely no idea where that came from. I don't even know how I could have had a conflict with a pharmacist. I mean, they don't...

Q. You will agree that Dr. Berger did write that to Dr. Shake?

A. Yeah, I do. I do. I don't know where she got that information, but I'm just saying that, you know, by the time she spoke to me, and then subsequently wrote this e-mail on Papin 438, that by the time she spoke to me, she never brought up these issues. And by the time she wrote this e-mail, she's not writing about them either. The only thing that she's talking about are these issues here. It was never brought up to her, I guess, in my presence, and then -- no longer is it that I've had a fallen out with all four CV ICU nurses and a pharmacist, you know.

I think the difference between these

e-mails is I was there in person to kind of, you know -- people aren't going say anything that they want to say when I'm present. If that makes sense. It's harder to say something about someone when they're right there to defend themselves.

Q. So that kind of concluded your CT surgery rotation. And that would have ended at the end of August?

A. That's correct.

Q. Where did you go next?

A. Next was the VA, Veterans Affairs.

Q. So as these evaluations had started coming in at the end of the rotation, did you have anymore conversations with Dr. Earl about the evaluations and -- I believe in your talk with HR, you told them that he had met with you several times.

A. Yeah. I don't -- if you can tell me -- I would need some context on that. He did meet with me more than once. I don't recall him meeting with me more than once prior to the VA. I think we met one time, and it was just to talk about, you know -- like the gist of it was that we need to avoid these types of situations. I don't blame you for this occurring, but the goal is to

not have it come to blows.

Q. That was in reference to this Josh Sabins' incident?

A. That's correct.

Q. At that time you didn't have another meeting with him until when?

A. Give me a second here. So if I recall correctly, the next time that I met with Dr. Earl would have been for the semi-annual evaluations on or about November 29th, something like that. November 20th, 29th, something like that.

Q. Would that be the only in-person meeting? What about phone calls or other conferences?

A. To the best of my memory, that would have been the next time that we had like an in-person, you know, meeting about my progress.

Now, during that time, in November, I would have, you know, talked with him and seen him a bunch because I was on his service -- that would have been October that I was on his service, I believe. Because now we're in September, which is the VA; is that correct?

Q. Uh-huh. (Affirmative response.)

A. And October was transplant. So I would

have seen him and interacted with him, but we weren't talking specifically about any issues or my progress or anything like that. In passing, in October, I told him, Dr. Earl, I really want to make sure I do a good job for you on the service, please let me know if anything comes up.

And we had another conversation again just in passing towards the end of the rotation where I said, Dr. Earl, how did I do? He said you did great. I've been checking up about you, I haven't heard anything bad. I asked his nurse practitioner, Ashley Seawright, she told me I did a great job. There's text messages. I think we produced those to you.

The next formal meeting where it was just anything more than that would have been, I believe it was November 29th.

Q. What about -- I read reference to a meeting of you and him outside of OR-16.

A. I have as well. I don't recall that.

Q. Don't recall the meeting?

A. I don't recall that ever occurring.

Q. Another incident that I want to talk about was a phone call that the two of you had when he was -- he was at the CCC meeting, and it

was about leaving a note for sign out.

A. Right.

Q. What do you remember of that?

A. I don't remember anything about that at all. I don't recall it occurring. I do recall him giving me a -- and I don't recall that ever -- let me make this clear. I don't recall him ever calling me about that and I don't recall and dispute that that ever happened. I never would have just left a note, you know, like a Dear John and just walked out. That would have never been something that I did.

I do recall one specific instance where he called me. I don't recall when it occurred, but I was in clinic and the clinic was over in Brandon, you know, 20, 25 minutes away from the hospital and it was about a minute away from where I lived. And I got done like at 6:30, sign out was at 6:00. So I called the resident -- the intern who I was supposed to sign out to, and I said, hey, I'm 25 minutes away, is it okay if I give you verbal sign out this one time? Because I'm a minute from my place and I have to come back 25 minutes, it won't be until 7:00 I get back and it was 25 minutes back. And I don't remember the

intern's name, but they were fine with it.

Evidently, a senior resident became aware of that and reported it to Dr. Earl. Dr. Earl called me and told me, hey, we can't do that. It has to be in person every time. I said, okay. That is what I recall. And it never occurred ever again.

Q. Who is Dr. Laura Vick?

A. Dr. Laura Vick, she was a general surgery attending. I interacted with her on general surgery B.

Q. What is general surgery B?

A. There's just -- there used to be an A service, I think that's the only one. It used to be A and B for the general surgery for things like gallbladders, things that weren't specialized. Cardiothoracic, anything to do with the heart surgery, that's on cardiothoracic. If you come in and you're in some sort of a trauma, that's on trauma. This would be like if you got your gallbladder removed or part of your intestine or something like that. Something that didn't fall anywhere else. Just like the core general surgery stuff that we would see -- was seen on general surgery. I think general surgery B. There used

to be an A and a B, and it was just still called B.

Q. But she was over B?

A. She was over B, yes.

Q. Do you know if she's also the wound care doctor?

A. Yes, she kind of carved out a little niche for herself seeing wound care things.

Q. Why would she have reported to Dr. Earl that you left a note for sign out if you hadn't left a note for sign out?

A. I don't recall that even being said. I think that might be -- someone is mistaken here. I don't recall that was ever said. The only time I've ever heard that was in Dr. Earl's deposition. That's the only time I've ever heard that. And from recollection, I don't think he said that, that Dr. Vick told him that I didn't leave sign out, because attendings aren't present for sign out. Whether I did or whether I didn't or anybody did or didn't, she wouldn't have known the sign out even occurred or when it was occurring or, you know, the facts of it. It was done in the resident lounge and attendings weren't there.

Q. Where is the resident lounge?

A. So it's hard for me to remember if it was like -- when you enter the hospital, as you're walking, I think you kind of follow on the right side of the corridor, you'll see like the cafeteria, you go past that, and you keep going to the right. It's kind of toward the end to the back on the way to the Children's Hospital.

Q. Okay.

A. Now, I don't remember if that was on the ground floor or the first floor. They were the same thing. If you remember where the cafeteria is, I think it was on the same floor as the cafeteria, kind of far to the back on the way to the Children's Hospital.

Q. Is it still in the main hospital?

A. Yes.

Q. Are you familiar with what the Clinical Competency Committee, or CCC, is?

A. I'm familiar with what it is. I'm not familiar with exactly what they did.

(Exhibit 10 marked for identification.)

Q. (By Mr. Whitfield) I'll hand you what is marked as Exhibit No. 10, which are the notes from the CCC meeting. I want to refer you to the back page first.

A. Okay.

Q. These were documents that were produced in discovery. Have you reviewed this document?

A. I don't believe so. I'm not noticing the sad face between the P either. I feel like I would have seen this before. There's a handwritten "Papin" with a sad face in the P, second P. I don't recall ever seeing this.

Once more, on peds, I didn't do a pediatric surgery rotation. So my semi-annual review would have been late November, we'll say, I think it was the 29th, but it would have been then. At no point ever did I ever do a ped surgery rotation.

I'm looking at this, "Multiple providers had trouble working with him, poor communicator." Never did a rotation on pediatric surgery, so I don't know --

Q. What about pediatric physicians?

A. There were times where on call we would have, you know -- like if something -- if a trauma came into the -- if it was a kid, they would go to the pediatric emergency room. But I mean, I would have incredibly minimal interaction with attendings or anybody on the peds side. It would

basically be me go get a story, write up a history and physical, and that was it. Certainly never have -- I couldn't even tell you the name of a pediatric surgeon, honestly. I never had a rotation on peds.

Q. Surgery B, it says, "Told senior faculty he had communicated risk factors and had not."

A. Yeah, I -- I don't know what that's referring to. I can tell you there's never been a time where I have said I've done something and lied about it. That's never happened.

Q. On here it says, "Left a note for sign out" and "be honest." You see those two comments?

A. I do see that.

Q. As we're sitting here in the deposition, have you ever left a note for sign out?

A. I don't recall ever leaving a note for sign out. Sign-out procedure is you print out your patient census, all the patients on your list, and then their room numbers would be there, a courtesy thing. You hand that to the person that you're out going to, and then they take notes on that, and then that's their list for the night. If anything occurs, they have a nice little list there for themselves to write things in on. It's

a way of them to keep track of who their patients are, where they are, things like that. I don't know if they're referring to that, but that was done every day. But no, there was never a time where I left a patient -- where I left a note for sign out and that was it.

I do recall the time when I was -- had to stay late in clinic and called and asked if I could do a verbal sign out. No, there was never a time where I just left a note and walked away and that was it, never.

Q. Dr. Earl never called you about leaving a note for sign out?

A. Unless what he's saying -- I don't know if he's mistaken. It would be inaccurate to say that he called me about leaving a note for sign out. The time that he did call was when I asked if I could call verbally. That was the time that I recall. And he did tell me not to do that anymore.

(Exhibit 11 marked for identification.)

Q. (By Mr. Whitfield) I'm going to hand you what is marked as Exhibit No. 11. Do you recognize these documents?

A. Is the question have I ever seen this?

Q. That's the first one.
A. This document here?
Q. Yes.
A. 655 to -- where's 656?
Q. They're out of order.
A. I don't think I've ever seen 656. These look like what were probably notes from somebody during the semi-annual review, would be my guess. But I do recall seeing 655 and 657 and being given these in my semi-annual review.
Q. So in the semi-annual on page 655, I'm showing you, you had a grade of CD or critically deficient in Systems-Based Practice 1, critically deficient in Systems-Based Practice 2, critically deficient in Practice-Based Learning & Improvement PBLI3. Critically deficient in Professionalism 1, critically deficient in Interpersonal & Communication Skills ISC1, critically deficient in Interpersonal & Communication Skills ICS2, and critically deficient in Interpersonal & Communication Skills ICS3.
A. I do see that.
Q. Does that accurately state what's on the page?
A. It does.

Q. At the end there's some notes. Is that your signature and the date?

A. That looks like it, yes.

Q. And Dr. Earl, again, tells you there's communication and professionalism concerns, ownership of task, communicate concerns, must treat nurses and allied health staff with respect, do not be arrogant.

So you received that feedback?

A. I do, or I did. This is what he said and, you know, I don't know about anybody else, but when someone tells me communication and professionalism concerns, those are incredibly broad. I still to this day don't understand what he meant. Ownership of task -- I'm trying to be as clear as possible here. He refused to give any more clarity into what this said.

Communicate concerns, I don't what -- is he telling me that I want to communicate concerns, that I should communicate more communicate concerns? I don't know. Must treat nurses in allied health with respect, but I still don't have an instance where I can think of that I treated someone without respect. The only incident that I can recall was the negative was the Josh Sabins

incident. Do not be arrogant, again, overly broad. I can't possibly know what that's referring to.

And then on this sheet, you know, obviously to me in hearing -- I didn't know what the clinical milestones were and things like that. But hearing seven critical deficiencies, that sounded serious to me.

And when I would ask, he became irate, he became angry. Joey, you always do this, you know. Feedback to you is a sign in the OR. When someone stops listening to your presentation, that's your feedback. When somebody tries -- there's a big push in surgery for feedback and -- I don't believe in that. You need to start figuring it out for yourself.

When I asked for any context, I would just always get this.

Again, I'm looking at this, I still don't understand this. Patient Care PC1, what does that mean? A 1.0 evaluation 2.9. When you go down to System-Based Practice SBP1, it says CD where Patient Care PC1 said 1. And then evaluations Q6 it says 2.9, and it says the exact same thing for PC1 2.9, but PC1 is not a CD. So I

don't know what scale this is on. It doesn't seem to correspond to -- is it a mean, median average, standard deviation -- I don't know what it is, but I'm looking at this and I see 2.9 for SBP1, 2.9 for PC1. They're both the same number. One is a critical deficiency, one is not. When I asked about that, he told me to figure it out.

This is unreadable to me. And this is the extent of the feedback that I got. It makes it impossible to improve.

Q. You actually had a meeting with Dr. Earl where he was going over this with you?

A. No, he didn't -- what he said was basically this. And then as I'm reading the notes -- I mean, I don't remember the exact entirety of the conversation, but the notes here on 656 at the back of this were some of the things that we discussed, you know -- these are notes from -- I'm going to guess this is Renee, because she was present. Quiet around -- quiet, around, do what needs to be done, only read -- only wrote out -- you know. I'm agreeing with statements.

Obviously, you know, hierarchy, trust, respect must be earned -- hard to earn, easy to break, things like that. He did discuss this

hierarchy, trust and respect must be earned, but didn't give any sort of context into it. You know, where am I losing trust? Where am I losing respect? Understanding feedback, things like that.

So he went over generalities to the extent -- I mean, he summarizes exactly what he said right here on 657. To me, it's nothing to go off of. I was begging him, you know, Dr. Earl, I would really, really like to know the context of what's going on because I want to be better. I want to succeed here. I want to do a good job. If you're not giving me the context or where these are coming from, what's happening, it makes it really, really difficult for me. Because I clearly can't recall anytime where I've been unprofessional or I've treated nurses without respect, say, for the Josh Sabins incident. And even then, I thought I was respectful but firm. I just wasn't going to let myself be bullied.

He handed me this sheet, but I mean, he gave me no more context than this. I don't know what SBP1 means. I don't know what SBP2 means. I don't know what the scale means. I don't know what this is --

Yes, he handed this to me; yes, we talked about it. The highlights of which are written here in the margin. But I was no better off leaving this meeting than before I went into it.

Q. The next meeting, would that have been your meeting with him on December 20th?

A. Yes, sir.

(Exhibit 12 marked for identification.)

Q. (By Mr. Whitfield) I'm going to hand you what has been marked as Exhibit No. 12. Have you seen this e-mail before?

A. Only through discovery, but yes.

Q. So in this it says, "At our meeting with Joe today we discussed the recurring issues of professionalism that have been present through much of the first six months of his residency. These are well documented in his evaluations and I have gotten feedback from nurses, co-residents, and staff regarding his behavior. Specific examples of this behavior are: Unwillingness to help with tasks, leaving the hospital during duty hours (to exercise), condescending tone to nurses and fellow residents, leaving clinics without telling anyone, and poor inter-professional

communication."

Did he go over all of these with you in that meeting?

A. No, I don't believe that we discussed leaving clinics without telling anyone. And I wasn't -- I would have assumed that I would have been the "To" on this e-mail, and then maybe Renee and himself would have been CCed. I don't know why I was not included on this e-mail. I would assume because of that, but I don't know.

I was never told that I was leaving clinics without telling anybody. But we did go over unwillingness to help with tasks. We did go over No. 2, leaving the hospital during duty hours to exercise. And if I recall correctly, that was 99 percent of what that meeting was. It was because he had been given a text message between myself and Meghan Mahoney, and he was upset that I had asked to go to -- I had asked to go on a run. He didn't know that I didn't go. I told him that. I also clarified, Dr. Earl, it seems like you're not operating with all of the facts. I asked her, however long ago, if I could go on a run and she told me I could and she let me go. So it seems like a trap now when I'm asking.

And I didn't go without permission. I asked, waited and waited. And when she told me I couldn't go, I didn't go. Seems like you were told that I asked this time as if it were the first time and I hadn't been given permission beforehand. I've got a text message to prove that. Do you want to look at it? No, I don't. And then we discussed a few of these other things.

Q. What did you discuss about unwillingness to help with tasks?

A. Just that. He went into no more depth, unwillingness to help with tasks than that. I told him, Dr. Earl, I can tell you, there's never been a time where I just refused a task or I've been unwilling to help with tasks. Could you give me some context in that? Joey, you always ask about this. This is what it is, fix it. Okay.

Leaving the hospital during duty hours, obviously that was the main theme of the whole conversation, so that I had context to, because he had identified the text message and that it came from Meghan showing things like that.

Q. What about the condescending tone to nurses and fellow residents?

A. He brought that up. That is about as

good of a summary as the entirety of the conversation that he and I had. And I can't recall ever being condescending to a nurse or a fellow resident. If you wanted to call it condescending, the only text message, which I believe has been produced to you, and I think we might have been produced to you, is between Erin Moore on that code blue incident where he's telling me it's not a good look to not come to the code blue. I told him, you know what's not a good look is for you to be standing there right next me, you didn't move, you didn't run over there, you did nothing. When we finished, I walked out. I didn't know it was a patient of mine, and now, however many minutes later, you're telling me it's not a good look that this happened.

So if that is called condescending, I could see that, possibly, that I was standing up for myself and, you know, defending my own professionalism in some way. It felt like kind of a personal attack when someone attacks your work ethic and how you take care of your patients. That felt personal to me.

The last one, if we could just skip over to that one, for inter-professional communication.

Again, he said that, would give me no sort of feedback or direction as to what that meant. I mean, I don't remember if it was the November 29th meeting or this one, but like I described before, I told him, Dr. Earl, I don't mean to be flip, but I'm speaking English. I don't know where or how communication is breaking down. I can't think of an instance of this, but I feel like I'm communicating to the best of my ability here. And as you and I are communicating, I feel like you're understanding me. Where is this breaking down? If you could tell me, I could make an effort to make this better. And nothing.

Q. Didn't the code blue happen over the holiday time?

A. I -- I don't recall. I want to say I don't think so, but I don't recall.

Q. I wanted to clear that up for the record. I'm just asking.

A. I don't recall. I think there's documents of when that happened. It would have been in a text message. I can check my phone right now, actually. I can tell you in a second when that occurred.

Yeah, it looks like December 12th, 2016

was when it happened, which would not have been the holidays.

Q. Speaking of the code blue, that occurred as you were signing out?

A. The code blue, I mean, this was a while ago. But what I recall is the code blue came over after I had signed out. I was still like on campus. I was still in the resident lounge when it occurred. It just said code blue, three north. There's a lot of patients on three north. It didn't even occur to me that it would have been one of my patients. How ever long I had been at UMMC to that point, a code blue had never been called on one of my patients, you know, that I can recall. And certainly not when I was present.

So it's something that's so infrequent and so rare, it just didn't even occur to me that that could possibly be one of my patients. I was sitting there with the night team, because that's who you sign out to, the people who are going to be taking over for you at night. So the night team would have been the one to have been running over there if they had known, too. I'm sitting with them, I talked a little bit, and then I ended up leaving.

But yeah, no, I was -- Erin, who was the one who sent me the text message that said it was not a good look was the one I had signed out to. Now, if it was -- to me, it's kind of ridiculous that he was sending me this text message. I'm standing right there with you. If he would have started running, I would have started running. Nobody else was. Nobody was doing anything. It didn't even occur to me, didn't even think. I heard a code blue, but I didn't think it was one of my patients.

I left and then I got a text message from Will Bruch, who is another intern with me on trauma service. He told me about it. I asked what was going on. And then I think in the meantime I got a text from Erin saying it was a bad look. You know, a code was called on one of your patients. It just felt like an attack. There was no call, hey, come back or anything like that.

Q. Was Erin a first-year intern?

A. That's right.

Q. So you, Erin and Will Bruch were all in the same class so to speak?

A. That's right. Just one small

clarification is that I was a general surgery resident, they were urology residents, interns. But their first year was entirely with us. So they were entirely part of the general surgery program, but their second year forward, they were solely with urology. But yes, we were all on the same level. You could technically consider us all general surgery residents at that point.

Q. I guess I've heard the expectation would have been because it was your patient, you should have called or checked in on. Because coming off the dayshift, you would have had the most medical knowledge of the patient for the team?

A. I don't know that that was -- I've heard that myself, too, subsequent to it. I don't know if that was an expectation, but certainly it would have been an instinct of mine had I known this was a patient -- had they said code blue three north room number 317, or whatever the patient's number -- I'm just guessing -- 317 and I had known that that was my patient, I absolutely would have gone. Or if I had walked by and seen a code blue occurring, I actually would have stepped in and offered my assistance.

First, the role of an intern is minimal

on the team. But still, you know, if I can provide anything, if I can do anything at all, take notes, provide some sort of -- oh, he's diabetic, not that he was, but just some minor, like, way to help, I would have.

Q. Looking back on it, hindsight is 20/20. But as the intern, probably should have called and just said, hey, whose patient is this?

A. I mean, I wouldn't agree with that I probably should have. I would have wanted to for my own. But in terms of like, you know, formally whose duty is it to take care of a patient, I had already signed out the patient's care. I know there's some debate about whether it's a shift or not. The fact is, it was a shift from 6:00 a.m. to 6:00 p.m. I didn't consider it shiftwork. You know, you sign out at 6:00, if you've got more things to do, there are more things pending, you stay. No problem with that whatsoever.

Formerly speaking, it was then Erin's patient. He had the sign out, he had the list, he had everything he needed to know. There was no way to predict that this patient was going to have a code blue, so there was nothing more that I could have prepared him with. Had I known,

absolutely I would have gone.

Q. All right. We've made it about another hour and 15 minutes.

(Off the record.)

Q. (By Mr. Whitfield) So now we've gone through your rotations, and we've gone through CV ICU, CT surgery, then you went to VA, then you went to transplant, surgery B. And then December of 2016 was trauma?

A. That's right.

Q. Who was your chief on the -- resident chief on the trauma service?

A. It would have been Meghan Mahoney.

Q. She was a fourth year at that time?

A. Yeah, she was clinically a fourth year. She had done a fellowship in critical care already. So the residency is your first year PGY1, PGY2, PGY3, 4, 5, and you're done. She had kind of taken a break and done a fellowship in critical care where you have to take care of very sick patients in an ICU setting. She had been at the hospital -- I think that was her fifth year, but she's clinically a fourth year.

Q. Does it matter when you take a fellowship? Can you take that at anytime or is it

like a set procedure for taking fellowships?

A. Yeah, usually most of them want you to have completed residency entirely. There's a few that let you do in your third or fourth year. That's one of them. But generally, for example, plastics is a fellowship. Generally you have to have completed five years, or you apply in your fourth or fifth year. But it's after you've completed your residency. Most of them are like that.

Q. You came on to Meghan's service in December?

A. That's correct.

Q. That was trauma?

A. That's right. Meghan started at that time, too.

Q. So both of you started December 1st?

A. That's right.

Q. Tell me about working with Meghan.

A. Anything specifically?

Q. How did y'all interact with one another?

A. I guess I would characterize it as somewhat difficult from the beginning. I think Meghan has a bit of a reputation. I had worked with her a few times on call. Her nickname in the

program is the red dragon. And when we first started, I remember her for the first week, it was the weirdest thing that she would say to me randomly -- we would be in the resident room just kind of hanging out with the other team members, and she would say, am I going to have a problem with you -- just out of nowhere, am I going to have a problem with you, Joe? I said, no, Meghan. Is there any reason you think that? And she wouldn't answer or just say no or something like that. But she did that every single day for about four days straight.

Finally, I said, Meghan, where is this coming from? I don't think I'm going to have a problem with you. Have you had one with me at all?

No, I'm just watching you.

I'm like, okay. And that was really kind of how it started, but, you know, our interactions I would say initially were professional. But she's always got kind of like -- I don't know how to say it other than she's got kind of a brusk quality about her. She's just not a very -- I don't know if nice is the right word, but she's just not a very nice

person. But was professional.

We would communicate with each other, you know, everything got done in the beginning. And then as we moved forward, I think things started to deteriorate. You know, she started to say like, you know, ruder things or correct me about things in public. Some things that weren't, you know, even necessarily my responsibility or my fault. Not saying -- something that I had nothing to do with. It would be completely peripherally related to trauma and she would yell at me because something was going wrong, something like that.

Q. Is this where the number list came up?

A. That's where I was heading towards. There was an interaction probably midway through the rotation, mid-December, I couldn't tell you exactly when it was. We were down in the resident reading room, I think it's called, for radiology. It's right next to the emergency room on the ground floor. We were down there, there were like -- I want to say urology -- urology resident, I think there might have been more, orthopedic surgery residents, urology residents, may or may not have been some emergency medicine residents, you know, radiology techs. There were a bunch of

people there.

I don't recall what it was that she yelled at me for, but she yelled at me. And this had been how ever many -- it wasn't the first time, I'll say. I told her, Meghan, happy to accept feedback, want to get better, but doing this in front of people is not the way to give me feedback. Please reserve this for in private. We can certainly talk in private.

She became enraged. She asked me to step outside the room. She's telling me -- she's angry at this point. I have been warned by Renee to watch out for you. I have been told that you could be a problem, so I'm watching out for you. You're just getting difficult. I'm going to give you feedback whenever I want, whatever.

And I said, that's up to you. I can't stop you, but it's not really the best to give this in public to try and humiliate me. And then -- I don't remember the rest of the conversation. It basically ended there. And then maybe that day, maybe the next day, she came up with this numbering system.

The numbering system -- she came up with it publicly. It wasn't designed as another

humiliation technique. It was 1 through 5. Like No. 5 -- I don't remember the numbers. One of them was, Joe, you're a douche, another one was, Joe, you're an asshole. There were variations on that same theme. All of them were some sort of insult towards me. And from that point forward she would say, that's a 5.

I got a text message from her where I was talking about -- I don't know if that's been turned over. I think it has, but I'm not sure -- but, you know, where she's telling me -- I told her, oh, one of the nurses on whatever unit said I was cute. They're back in my good book or something like that. I was just joking with her. And then she responded, 5. I think that was the douche. You're being a douche.

And that's what it was. It was just another one of her tools to try and humiliate me and embarrass me. From what I can assume is that Renee had clued her in to be watching out for me and looking out for me. It says right here, I'm referring to Exhibit 12, 459, bottom paragraph. "Additionally, I told him I would be soliciting feedback regarding his performance from nurses, residents and faculty."

And I would assume that the way that was done was through Renee. And she told me in anger, oh, Renee told me to watch out for you. This is just kind of more of the same -- I couldn't really understand where it was coming from. She just seemed to be angry. She's angry with everybody at all times. She just seemed to be angrier with me. Didn't really know where it was coming from.

So it just continued on right there. So I would say it progressed from just kind of at least cordial, I would think, to some like weird comments about, am I going to have a problem with you, to just kind of outright dysfunctional the way that she was speaking to me. She would curse at me over text messages, things like that. I think those would have been produced, things like that. Giving me feedback publicly, which I've already discussed that.

These are all things that are just, you know -- I would think that most managers, most people managing people wouldn't be doing. If you want someone to genuinely improve, don't scream at them without any sort of action. She just screamed to scream. It's not like she's trying to correct something and have me do better and tell

me this is what should be done, whatever. You can scream at me, that's surgery. I'm not -- people scream, that's fine. But, like the way that she was doing it, it was just specifically to humiliate and just to embarrass. There was no real point to it.

Finally, I took a little issue with it and told her. And then I would say that, from that point forward, it was kind of a disfunctional relationship. I still communicated everything that I needed to with her. I still -- she's still my superior, she's still my boss, technically. If there was ever a patient issue, I brought it up to her, still communicated about patients. That never changed.

Q. Now, one of the biggest issues that apparently occurred on her service was with a decubitus ulcer patient. I'm sure you heard a lot and read a lot on this particular patient.

A. That's right.

Q. Did she have a rule that you were supposed to check the backsides on Mondays?

A. She did.

Q. Do you remember her asking you if you had checked this patient's backside on the

Mondays?

A. I don't recall if it was Mondays. She did have a rule that backsides needed to be checked weekly. I don't recall if it was Mondays, but I do recall her asking me whether I checked the patient's back, and whether I checked this specific patient's back.

I think December 5th would have been the first Monday. Will Bruch had the patient. I don't know what was said or what was asked. I wasn't around for that. I don't know if she even asked him or not. She did ask me at least once, and I -- she told me, okay, it's time to check, and then I would check it. Because it's so involved, it's such a process to -- we have so many patients and so little time. And to flip somebody over, you have to get help from a nurse. It takes a while. So we wouldn't really do it before rounds.

So pre-rounding, we wouldn't do it before rounds. We would go through, we would round and things like that. Sometimes the attending would check the person's back and we would go through that procedure. But that was up to them. But when she had asked me to, I would

come back later once we finished rounds and everything, and then go back and look at it. And then during what we call p.m. rounds, afternoon rounds, I would report to her.

(Off the record.)

(Exhibit 13 marked for identification.)

Q. (By Mr. Whitfield) So I'm handing you what's been marked as Exhibit No. 13. This is your progress note for December 27th, 2016 on the decubitus ulcer patient.

A. Okay.

Q. I'm going to take a few minutes and kind of go through it with you. On the first page there's a section called Physical Exam. Is that where you document your physical exam of the patient?

A. That's correct.

Q. So kind of walk me through your physical exam and what you did.

A. Sure. So you start from the top, you kind of look around. So, Generally: NAD, stands for no acute distress. So he's sitting, looking pretty comfortably. HENT, that's head, neck, things likes that. NCAT stands for normocephalic, so nothing wrong with his head. Atraumatic,

basically his head and neck looked okay, essentially. His neck, he's got a Miami J collar on, which is a type of collar that they put over somebody's neck.

Cardiovascular. 2 plus distal pulses. So you check their wrists, you check their -- the peripheral pulses in their ankles. And 2 plus means he's got two pulses.

Pulmonary/Chest. Looked at his lungs. He's got non-labored respirations, so he was comfortable breathing. And both sides are rising equally. I didn't notice anything wrong with his breathing.

Abdominal exam. You touch it, it looks soft. Looking for distention or anything like that, any hardness because he might -- you know, after surgery, you could you be at risk for like stool getting trapped in your abdomen or something like that, and it could cause an obstruction or whatever, something like that. You could be worried about that. Everything was fine there.

Musculoskeletal exam. He's a quadriplegic, so there's no need to assess his strength and muscles and things like that. Skin is warm and dry. No rash noted. He's not

diaphoretic, meaning he's not sweating. No redness. Pallor is -- he isn't pale or anything like that. I then noted that there's an abdominal pad over sacrum where that surgery occurred from three days prior -- four days prior.

And then Psychiatric. Normal mood and affect. He didn't seem deranged or anything like that.

Q. Going -- I guess you've got the lab results that follow that.

A. That's right. This comes auto-populated into the note.

Q. Everything after the physical exam was auto -- or the vitals, ins and outs, physical exam, everything else is auto-populated?

A. No. We can go through it. So last 24 hours, patient states he's doing well and in no pain. Denies fever, chill, cough. I typed that in manually. Vitals is pulled in, ins and outs are pulled in. Physical exam, I type that out. Recent labs are pulled in. At the top of 3402, these are still labs. Those are pulled in.

Imaging, they can pull some stuff in automatically, but the way that it pulls in is odd. So it looks like I went in -- because I

think the ultrasound -- if I remember correctly, ultrasound isn't necessarily considered imaging, so I went in. Bilateral lower extremity ultrasound 12:23. I typed that in. And then active problemist, that's all auto-populated.

Assessment and Plan, I wrote. And then -- all of this looks like -- from A/P, I wrote that. And then all the way down, I wrote that. And all the way down. The neurosurgery recs, I would have copied those in. But I went and manually retrieved those.

Q. Would you basically go to another note, copy and paste?

A. Yes. So when I wrote neurosurgery recs 11:18, that's a copy and paste. PT recs, I went in -- I think you have to read those. But, yeah, they said acute rehab consult. I think I typed that in. Endocrinology recs 12:22, I think I copy/pasted that. DM Type 2, that's diabetes, Mellitus Type 2. Will continue lantus 15 units and stop premeal humalog. That would be a copy/paste on that. That is something we did on trauma regularly because it's a service that requires heavily on consultants.

So neurosurgery, orthopedic surgery,

endocrinology, rehab or physical therapy, you know, different people have different recommendations, and we're just kind of managing it all. Usually it's trauma does the initial surgery, and then they're admitted under our service, but everybody else comes in and does their thing.

We did this as kind of a practice to keep everything in one place so you didn't have to go to the neurosurgery and go -- which would have been a month-and-a-half back. You could just keep it all in one place, keep it updated, easy to keep track.

(Exhibit 14 marked for identification.)

Q. (By Mr. Whitfield) So I've handed you what's been marked as Exhibit No. 14. It's a copy of your transcript with Human Resources.

A. Okay.

Q. Have you had a chance to review that document?

A. I have in the past, you know, when it came out in discovery.

Q. I want to take you to on the bottom, it's Bates labeled pages 35 and 36.

A. Okay.

Q. So on page 35, it's the actual transcript page 17. This is where you're talking to Ms. Whitlock about the decubitus ulcer patient?

A. This is bottom right-hand corner -- bottom right quarter of the page; is that correct?

Q. Correct. And going on to the next page.

A. Yes, sir.

Q. She relays this concern to you that this has been brought up, that you should -- "But the premise is that with it being stage four, you should have seen it. That it would not have occurred over a period of a day or two."

You said that you may have a gap in knowledge base of looking at this wound. That's on page 18.

A. Okay. But the day or two thing, is that line 21 of page 17? That would not have occurred over a period of a day or two --

Q. Yes, starting there, and then going to the next page.

A. Okay.

Q. You say, "Right. Right. No, you're right. And, I mean, if it's -- like I said, I can't comment because I don't know exactly which patient this is." And you go into, "I think it

was more of a gap in knowledge." It's on line 7 of page 18 of the transcript. "I think it was more a gap in knowledge than -- you know, it didn't look floridly terrible" -- is that right, "floridly terrible?"

A. Yeah.

Q. And this was -- "I'm talking about, the wound ostomy -- this is the day before I went on Christmas vacation, the wound ostomy nurse put it the note that day, and I had seen it, too."

A. Sure.

Q. Would that be December 22nd, the day you left to go on Christmas vacation?

A. That's correct.

Q. That's when you became aware of was when the wound ostomy nurse came in on December 22nd?

A. No. I -- no, that is not the day -- and that's not what's said either. That's not the day that I learned about it. I had known about it for quite sometime, and I had been relaying that message to Meghan for quite sometime. Their other interns, Will Bruch had known about it. It had been discovered actually before any of us had come onto the service. November 30th, I believe.

This is the first time -- on this day,

this is the first time that anybody had ever told me that the allegation of lying, that Dr. Earl brought up to me on January 10th, that this was the allegation of lying. This is the first time that I had heard about the allegation of lying and what -- I had been told about the allegation of lying. This is the first time I had any specificity in context to what it was.

Q. You saw it and you said I didn't think it was that bad?

A. That's correct.

Q. I believe you texted Meghan the day you left town saying Mr. _____ has an early decubitus wound?

A. Right. That's what I thought it was. That day -- that early, early morning, during the night, he had begun spiking fevers. Usually that's indicative of infection if there's sustained fevers and not just a bad read or something like that. The intern on the night service had ordered blood cultures, urinary cultures, respiratory cultures. And it takes about 24 hours for the blood cultures and anything to start coming back, and we didn't have a source in knowing that this guy had a decubitus ulcer. I

thought, well, this could possibly be a source of it.

So I made sure in text messages to update her, again, ahead -- that was unprompted, the text messages. It was just my way of saying he's got -- he's still got this decubitus ulcer, this could be another source.

Q. In your text you called it an early decubitus ulcer.

A. That's right. That's what I thought it was. What I'm referring to is in the gap in knowledge, is when I look at something -- when you open up a textbook just like you would as a lawyer or something, when I'm learning what a sacral decubitus ulcer is, you open it up -- and at least I've never seen a book where you can -- it shows you pictures, stage one goes down to whatever level, stage two, stage three, stage four, full thickness, whatever. You never see it with a big scab covering it.

From everything that I seen on my own personal body, anytime I've ever gotten a scab, the tissue underneath is healing. So I assumed incorrectly that a scab over something meant that it was healing. I couldn't see through the scab.

I thought it looked okay. And then what confirmed that is this wound nurse would continue to see this patient. And it just so happened on that day she had a picture of it and agreed. I didn't think it was that bad, she didn't think it was that bad. I was just letting her, her being Meghan, know.

(Exhibit 15 marked for identification.)

Q. (By Mr. Whitfield) Now I'm going to hand you what's been marked as Exhibit 15, which is your progress notes from December the 12th, which is a Monday.

A. Okay.

Q. What did you type in on this note and what was brought forward?

A. We can just start from the top. Surgery Progress Note. Pretty sure that would have been brought forward. The next line "NAEON," means no acute events overnight. I typed that. And then, "Complaining of some mild right shoulder pain. Denies shortness of breath or chest pain." That's something that I typed.

The next line is vitals. That would have been like auto-populated. Same with the intakes.

Right here where it says AAOx3. That's my physical exam. That means alert and oriented times three. Normocephalic atraumatic, that's the NCAT that we saw before. Aspen collar in place. Adequately perfused, that means his pulses are good. Breathing comfortably and he's quadriplegic.

"No results for inputs." That would have been auto-populated. The lab results are auto-populated. Recent labs, auto-populated. No results for inputs: INR, LABPROT, that's all auto-populated.

Assessment and Plan. This is where it starts to be me again. Assessment and Plan is me.

Endocrinology. This would have been manually retrieved, meaning I would have had to have gone and copied and pasted it from somewhere. This was endocrinology's recommendations. That's what they're recommending, but it's not auto-populated in that. When it's auto-populated, the note just pulls it instantly. I don't have to do anything. It's completely automated.

Discharge Planning. This would have been a copy/paste.

Neurosurgery, also copy/paste.

Trauma, this is where it's manually inputted. So IS, is incentive spirometry. That's to keep you blowing into this device. Because he's not moving around, to keep his lungs nice and healthy. Skin care. So wound care recs noted. There's a note to the decubitus ulcer wound care nurse. Because that was the only reason he was being seen. Those are noted.

I&O cath, DVT Prophylaxis, bowel regimen, pain control, all this is all me. CM for home versus Acute Rehab placement, that continues. This is copy/paste I'm sure. Result of family meeting was they would like patient to go to acute rehab. This might have been manual.

Then Wound Care Recs is the next line. That would have been typed by me. And then recommendation one through five would have been a copy/paste from the Wound Care Recs.

Q. But on this, it doesn't show where you did a physical exam on the backside.

A. Right. Like I said --

Q. It's not listed in your physical exam that you observed this person's backside or anything in here -- up here in the first page, AAOx3 through quadriplegic of your physical exam,

you don't list examining the backside?

A. Right. Like I said, it was because turning him, it was labor intensive. It requires multiple people. You had to coordinate that, you have to get a nurse in the room, things like that. Like I said, we were moving so quickly before rounds that we wouldn't document a back exam, but when we did them -- and the 12th was a Monday. So when we did them, we would report them to Meghan verbally. We would do them in the afternoon. Notes go in -- when did this note go in? 8:00 a.m. So notes were expected to go in because you needed your plan and everything in so that consultants and everything, anybody else looking to see this person, they're counting on us as the main team, they want to see this documentation.

So notes have to go in. Nobody ever documented a back exam on this patient throughout the entire month of December.

Q. Except for December 27th when you noted yours?

A. Well, on December 27th, then what you're doing is -- there's an acute change in circumstance then. Now we're seeing him postoperative for a surgery that was performed on

December 23rd. So now you have -- you're looking at a post-surgical patient. You've got to make that sure that wound isn't getting infected. You've got to look at the wound, things like that.

Q. So there's nothing in the medical record from the 12th to show that you examined the backside?

A. That's correct. To be clear, in nobody's physical exams are there back exams.

Q. But in yours, there's nothing in here to document that you did it?

A. That's correct. Like I said, the same of all other residents, attendings, everybody.

The 23rd -- the 23rd is the first time, if I remember correctly, Dr. Kutcher -- no, it would have been Dr. Carroll -- put in a note at the very top where he had tested, you know, the patient is going to the OR, exam revealed sacral decubitus wound. That was the first ever mention in a progress note of -- you know, of specifically of an exam.

Ronnie Keith Brown's note, if I recall correctly, on that day doesn't have -- on the day that it was -- you know, that it was discovered that the wound that was bad, Ronnie Keith Brown

doesn't have a physical exam on that day either.

(Exhibit 16 marked for identification.)

Q (By Mr. Whitfield) I'm going to do this as a composite exhibit. So I've handed you your progress notes on this patient from December 13th through December 22nd. Give you a chance to review them. But are they all basically in similar format to the one of December 12th that we just went through?

A. Yes, I would say so.

Q. In any of these notes do you have a documentation of where you rolled the patient over and examined the backside?

A. No, I don't. But, no resident did. Or nurse practitioner.

Q. I'm sure you've heard at this point, and you heard at the hearing that we had back at the Med Center appealing your termination, that Dr. Mahoney testified.

A. Yes.

Q. And she testified that she specifically asked you, did you turn the patient and was there a wound on his backside? And your answer was, yes, I did, and no, there isn't. And she felt that you had lied to her about that because the

wound had been there prior to December 12th.

A. I would classify that. I do recall that. I would say that's wholly inaccurate. She would ask me and I would tell her, yes, I looked at it; it doesn't look bad to me. And this is what wound care also recommended as well. So I think there's a little dispute there, too, because Earl at the beginning of the appeal transcript -- Earl at the beginning of the appeal stated that Meghan had told him that I would just reiterate what was said in the wound care notes, which in and of itself is notification that there is -- he's only being seen for one wound. In and of itself, if that were true, that's notification there is a wound.

Then she's saying that I was saying that there was no wound, which never happened. And now, I think -- I don't know what the latest story is or anything like that, but I -- I always went and did the exam that I said that I was going to do. And when I reported a finding, it was what I thought -- or I had done it and was reporting what I thought. What I saw when I looked at this patient's wound was that it's really not that bad, there's a scar over it. I thought the underlying

tissue was healing. It didn't look that bad.

Then, obviously when you take -- first, do no harm. So I'm not going to be peeling that off. I didn't know I needed to. I thought it was going to be healing. I thought it looked okay. But that's distinct from saying, there is no wound, which is not what I said. So eventually he started developing fevers, and that's what clued everybody in there's got to be some sort of infection. Blood cultures by the 23rd had been 24 hours, nothing there. That's kind of a red flag. You've got to go looking. It's somewhere. Where's the infection? It's somewhere.

I think urine cultures -- all the cultures have come back 24 hours. He's got a white blood cell count, which is an indication of infection. He's got a fever, another indication of infection. You've got to find it somewhere.

So they were cluing in just like I thought. As a doctor, you're supposed to have a differential diagnosis, you're supposed to think what the possibilities are for, you know, whatever you're looking at, what is ailing a patient. Just like I thought, maybe it could be this decubitus ulcer, maybe I'm wrong or something like that,

which is why I brought it up to her completely unprompted. And then I brought it up to her again in our p.m. rounds right before I left and told her, hey, there's a picture in the records, too. You can go look. There's a color picture right there.

Q. When you're saying you brought it up to her, you're referring to bringing it up to her in the text message on December 22nd?

A. So I brought that up to her unprompted. I told her, you know, Wound Care Recs are in, if I remember correct, or something to that effect. Wound Care Recs are in for _____ sacral decub, or at least it could be decub, which is what I thought it was.

Then later on, we met hours later for p.m. rounds. Basically me kind of signing off. She was letting me leave slightly early, because the flights at the Jackson airport -- you know how it is. In order to get a flight out, I had to leave slightly early. She was fine with that. I went to sign out to her, and I told her, he's still got these fevers. As I noted in my note, too, he's still got fever on the 22nd. All the cultures are drawn, we're doing the workup for it.

And I looked at his wound, it didn't look that bad to me. Wound Care saw it, too. They got a note from today, picture of it. And they always would put a picture in. There's a picture from today, go look at it.

And then I don't know what happened the next day, how they discovered it or anything like that. I do remember getting a text message from her the very next day.

And when I got a text message from her the very next day, I'll tell you, the way that it was sent -- and we talked before about how her tone is, how she kind of interacts with me. She's such a rude person that a neutral text message to me kind of made me think, why is she sending this to me, she knows who this patient is. She knows who has this decubitus wound, and the way that she's sending it to me is very odd. I made sure what I was telling her was correct. I responded pretty quickly. It was just an odd text message for me to receive.

So it's not necessarily surprising that later on, you know, she admits to having known exactly who had the patient the whole time. She knew exactly who it was. She admitted to it, said

that she knew. Sent me the text message for no other reason than to try and trap me so that she could them blame me for not knowing what she should have known that was all over the record that I had been telling her, that I had texted her about. I had done so many other things, and certainly no less than the other resident.

But she sends that text message because ultimately it falls on her. So she realized through all of this, oh, I can blame it on Joe, he's not here, he's on vacation, and people don't really like him anyway. I've been instructed by Renee to kind of watch out for him. So perfect scapegoat. I can't defend myself, can't do anything.

So she sends that, what I think, to catch me so she can point and say, see, I told you he was lying, he doesn't even know who the patient is. I got immediate alarms when she sent me that text message. The rest is history, I guess.

Q. Prior to December 22nd, do you have any text messages or e-mails or anything where you sent that telling Meghan this guy has a pressure wound?

A. I would have to check. I would suspect

not, but I would have to check. Because generally -- one, the reason why I sent it is because he's got a fever now. And the fact that we know he has a decubitus wound, obviously that could be a possible source. When I looked at it, it didn't look super red, it wasn't oozing around or anything like that. Like the things that I'm taught to look for, I'm not seeing those.

Usually when you have a decubitus wound, there's like redness all around it. It looks angry. Like an infection, if you've ever seen one. It's very easy to tell, usually, when something is infected. This didn't look like that to me. But I recognized it as a possible source.

So I texted her that to re-clue her in, because I'm not going to be here tomorrow, to be thinking about that, basically. So I don't know that I would have necessarily texted. Because he didn't have fevers or anything, he didn't have an infection. He had the wound, otherwise he was doing okay. It looked to be healing.

So I wouldn't have had a reason to necessarily update her, other than in person. Yeah, I rolled him over, I checked him, and it looks not too bad to me. And wound care dropped a

note the next day, they recommend continuing conservative treatment.

Q. But there's nothing other than the first text message on December 22nd where you said that?

A. There's nothing documented?

Q. Yes.

A. Not to my knowledge right now. I might have another text messages or something like that. Certainly if I do, I'll produce it, but not to my knowledge.

Q. There's nothing in the medical record that would have shown that you told her about it?

A. No. No. I mean, other than the fact that, you know, I'm copying Wound Care Recs every single day without fail. Wound Care Recs. And then there's five steps for each of them. He's only got one wound. I'm copying them forward. I don't know what more I can say in the notes. I mean, they're pretty clear. Wound care is dropping in notes themself and describing the wound itself. I think what you're asking me is if I documented a physical exam. No, nobody ever did. But in my notes, Wound Care Recs, every single day they're in there.

Q. This person had multiple wounds. Not

necessarily pressure ulcers, but he had gunshots all over, didn't he?

A. Yeah, but a gunshot wound is tiny. You're not going to be, you know, applying SANTYL nickel thick to wound bed. And I get what you're saying, but there was never any sort of like wound care consult out for that. And if you ever have a question about it, you can go to the wound care note where I'm copying it from and you can ask me. There's lots of different ways to get that sort of information if you're confused. That wouldn't be something that anyone was confused about.

Q. I'm not a doctor, so I don't know. That's why I was asking.

A. Yeah.

Q. Pardon us lay people.

A. Oh, no, no, no.

Q. So basically, the issue with what you told Dr. Mahoney on the 12th, the 19th, during rounds or whatever, there's no documentation that would back up either one of you as far as your conversation?

A. There's a text message on the 22nd, and then there's -- while it's not part of the -- of my notes, or anybody's notes in terms of a

physical exam. I mean, Wound Care Recs, to me -- if I were her and I were reading somebody's notes, assuming nothing else was said to me, which isn't true, but in this case, just assuming, if I were reading any of my residents' note, which she should have been doing at the very least, or just listening on rounds when things were presented, or anything, reading other provider notes, the wound care nurse, anything like that, you would have picked up on Wound Care Recs. It's in every single one of them. I would argue that there is documentation all over the place.

Q. As far as the conversation between the two of you.

A. You mean the specific --

Q. It's he said, she said. There's no other documentation to support the conversation one way or the other?

A. Sorry. If I'm understanding you correctly, what you're saying is there's no documentation that when I would go and look at the wound and communicate to her in the afternoon, that the wound looked okay to me, but still present, and that Wound Care Recs were in for whatever day, there's no documentation of that?

Q. Of the conversation.
A. As far as I know, there isn't, no. Right. As far as I know, on December 5th when it was Will Bruch's Monday, I don't think that there's documentation of that that I'm aware of either.
Q. So now, as we're moving through the Christmas holidays, we get to the first part of January. That's when it seems like a lot of the e-mails come in about what happened over the holidays. I'm sure you've seen all these e-mails as they were produced in the packet.
A. That's correct.
Q. One from Colin Muncie dealing with the admitting a patient to ICU, and that he had asked you to facilitate -- I don't know what the process entails, but you facilitate the process of getting this person admitted to ICU or let them know they're coming, and you didn't do it, is basically Colin's version of events.
A. Yeah. That's essentially what Colin said, but all he knows is what he was told by, I guess, somebody in the ICU. That's what he's saying, he doesn't know whether anything occurred or not. What he's relaying is what he had been

told by the ICU.

I think where it's inaccurate is that I had to go see this patient, you know, when they were in trauma, I had to go down and see them. I would also like to say, I don't know exactly who this patient is. The records haven't been turned over or anything like that. I know that I would have had to have seen this patient, I would have had to have done a history and physical, I would have had to have put in orders for their medications, you know, their precautions, where they're going to be admitted to, all these orders had to have been in. It's like a two-hour thing. You have to go down, talk to the patient, do all this, do a physical exam, and put the orders in. All that stuff, so two hours of work.

And then, you know, just to ensure great care, as a courtesy, you call the ICU and you tell them, hey, I've got this patient here, they were admitted for X, Y and Z, they're going to be coming to you guys, this is their history. Just so you know, they're coming. That's a quick head's up. And they can go read about them before they come and do whatever they need to do. But the patient is still coming. And all the orders

are in and all the work is in.

So basically what I'm being accused of is -- I'm certain as soon as we get the medical records you would see. It was never under dispute that I did all the work. It's basically I do two hours of work and then skip the last 20 seconds.

I'm telling you I did make the phone call. There's shift change, who knows. I don't know who he spoke to. I didn't get a name on who I spoke to. It's just a verbal thing, but it's one not required. All the notes were in. It's not like this patient was abandoned. They were coming from ER to the ICU. The fact that somehow the ball got dropped amongst them and the message wasn't relayed, I don't know anything about that. But the patient was still taken care of. It wasn't like he was sitting in an elevator not looked after.

What they're saying on the surface looks damning, but really it's -- I did two hours of work, and then they're saying I -- nobody could prove that this phone call occurred or didn't occur. So now I'm forced to, you know -- it did happen, but now I'm forced to dispute that when I've got the record. Certainly if we get it, it's

going to show I did the two hours of work, or how long it took --

Q. You didn't notify -- according to them you didn't notify the ICU?

A. I did notify the ICU, but yes, according to that -- well, not even according to Colin, according to what Colin had been told, so third, fourth hand by that point. He did say that there was a shift change and things like that. I honestly don't know. I wasn't there. I don't know what happened in the conversation. This wasn't Colin's observations, this is what Colin had been told.

Yes, that's what they were told. Things like that happen all the time. We call someone, things get lost in the shuffle. That happens all the time. But the verifiable important things that make them sure that a patient is cared for and that, you know, people know what's going on in the story -- the note was in there, that was there. The orders for how to take care of him, that was there. Whether the 20-second phone call that it would take to let them know, hey, this person is coming, here's a 20-second rundown. That's what they're disputing.

It happened. I made the phone call, but I have no way to prove it -- and there's no way to prove or disprove. How do I prove that I made a phone call at some point to somebody in the hospital? There's no way.

Q. There's no way to prove that you did, there's no way to prove that you didn't?

A. Right.

Q. The next e-mail that came in was from William Crews, who was, I believe, a medical student at the time.

A. Third-year medical student.

Q. Do you remember Mr. Crews?

A. I do.

Q. I guess he's Dr. Crews now.

A. Yeah.

Q. He basically said that you weren't doing the pre-rounds like you were supposed to, is the gist of his complaint. And that you were saying things in rounds that the patients had not told him or you weren't there for.

A. That is what he said. He said a few more things than that. We can go over those or we can just touch on that.

That I wasn't doing pre-rounds. The

issue with that -- and it's inaccurate and almost intentionally misleading to allow someone like a medical student to speak. It's almost like you coming into work and, say, you had an intern, and the intern saying you weren't working. You could have been at home, you could have been at the courthouse, you could have been anywhere. You don't need to check in with that person. So how would they possibly know what you're doing?

So the way that I would come in, just to give some context, and everybody would come in, is you come in in the morning, you're in the resident room, the medical student isn't there. So how would they know what time you arrive? You check out or sign out from your patients. This occurred to your patients, they give you a list, they tell you what happened. Okay. So now I've got, you know, the vitals, I've got my patient list.

So I would just go and round. Some people would go to the computer and read some things first. Depends on what you wanted to do. Sometimes I think Will would maybe stop off at the resident room where the medical students were hanging out on three north.

Q. Which Will are you referring to?

A. Will Bruch.
Q. Or Will Crews?
A. Will Bruch was the other intern on my service. We would both go and get sign out at 6:00 a.m., or sometimes 7:00 a.m., depending on the day, or whatever it was. Weekends started later and there was other successions. Generally, weekdays 6:00 a.m., we would go get sign out.
Sometimes we would both split up the list right then and there. We would pretty much always split up the list right then and there. Say there's 60 patients and there would be one nurse practitioner, one of us would notify the nurse practitioner you've got the list from this point down, and we've got these patients, and we would split them up.
Q. Will Bruch, B-R-U-C-H-S.
A. There's no S.
Will Bruch and I would meet, get signed out jointly, decide how we would split up the list, let the nurse practitioner know by text message or something like that -- usually it was him that text the nurse practitioner or call or whatever. We would split it up. Sometimes he would go and sit down and drop off his stuff over

in the resident room on three north. And I usually didn't bring a bag or anything like that, so I wouldn't go and drop anything off. I would just go straight and see patients. Sometimes he went straight, sometimes he wouldn't.

I would go and see patients, go around, see them, come back into the room probably about 6:45, and then read for patients until about -- it depended on when, but usually about 7:30 we would table round with Meghan, which means Meghan would come to that room, the second year resident would come to that room. Me and Will would be there and the med students would be there. And we would table round, and then we would round, formal round, at some point after that.

But to say that I'm not around or anything, the first person who would notify anybody that I never showed up is that person who's supposed to give me handoff. They would be the first person to notify anybody, hey, I never got handoff for half of trauma, or I never was able to sign off to Joe. So for a medical student to say that, odd.

Q. You would agree with me that just because you got sign out doesn't mean you went on

the rounds?

A. I mean, certainly you could, but the issue that you brought up to me was that because Will Crews did not see me means that I didn't go on round. That's what he said, if I'm interpreting things correctly. What I'm saying is, he would have no way to know. I agree with your statement that just because I showed up and took sign out doesn't necessarily mean that I went and rounded. I'm already there, what else am I going to be doing? I don't know why I wouldn't do that.

But yeah, sure, but it's certainly not the case that a medical student would ever -- if he's not there when I sign in and I don't ever have to speak to him at any point as a requirement, then I don't understand how he could possibly know where I am at any given time.

Q. I believe he also testified that he was getting different responses from the patients that you were giving at formal rounds?

A. Yeah. Again, another thing that probably would have come up from an attending, a senior resident, another resident, something like that. I think, you know, when you go in -- having

been a medical student myself, I think when you go in, people don't really want to talk to you that much. You're not a doctor yet, you're just learning, you know. So it's very easy, patients forget. You could ask a patient, you know, who was admitted a week before -- I had this happen all the time. Have you ever been in the hospital? And I'm looking at the record, I know they have been. No, I've never been in the hospital. People just forget or they think you mean something serious and being hospitalized for diabetes isn't serious or something.

You wake them up at 4:00 in the morning, they're on drugs, painkillers, things like that, they may not know exactly who's who. Usually they'll remember, oh, that's a doctor, that's not a doctor, something like that, but they're not going to remember names. The fact that he's eliciting something different, if it were material, it would have come up to somebody else and not just the medical student raising the flag. I think it's a very odd thing that it's a medical student raising flags here and nobody else is catching this.

I mean, it's tantamount to like, you

know, me going on rounds and just saying lies and nobody catching it and not rounding. How would I know the information about these patients if I hadn't gone and rounded myself and seen the records and gotten sign off, things like that? It would be really, really difficult to go on rounds and just guess correctly for every patient and pass the sniff test on every attending, senior resident and everything like that. It's really odd that he's commenting on that.

Q. I believe that was the way -- it's odd for a medical student to complain about anything?

A. You know, I don't know. I've never been, you know, the medical student administration or anything like that, so I don't know. I've been a medical student myself. I definitely heard of medical students complaining about abuse and neglect and all this other stuff, but I couldn't comment either way.

Q. Who is Ashley Griffin?

A. Ashley Griffin was a senior resident. She was a fourth year general surgery resident.

Q. She was on the same level as Meghan Mahoney and Sid Desai?

A. That's right.

Q. She also sent an e-mail listing out several concerns. The first one was about the code, the code blue. I think we've already talked about that. "Did not show up on time to pre-round prior to start of shift during holidays or to get sign out prior to the completion of the trip."

A. I don't know what that -- I don't know what that means, "prior to completion of the trip." I don't know what that means.

Q. "Did not show up on time to pre-round prior to start of shift during the holidays."

A. What she's referring to is, if I remember correctly, she had been told -- I wasn't present for any of this. She had been told from Will that I had not been present to pre-round.

Q. Which Will?

A. Will Crews, the medical student, that I had not been present to pre-round. We already discussed that point. But what she, I guess, doesn't remember or doesn't recall -- and I do have a text message to that effect and I don't know if it's been turned over or not, but we certainly can. But there was a point during the holidays, and I've got the text message, where, as a trauma resident, you carry -- or trauma intern,

you carry the trauma pager. So if a trauma shows up to the University of Mississippi hospital, your expectations is to drop everything at any time and go down. So that's what I did.

It happened to come on during a time where I was in the middle of the pre-rounding, if I correctly, and I had to text Ashley, hey, can I have some more time, I'm still downstairs seeing two alphas, which are like the highest level of acuity for traumas. For some reason that hadn't happened much in the mornings. People tend to either be asleep or not to cause too much trouble that early in the morning.

So I was downstairs, I asked her for more time, she said it was fine. But I'm assuming -- and that's the only thing that I can assume -- and again, because Will never knew where I was going. He would never know that I got a page and went down to go see traumas. Because I wouldn't go and let him know, hey, let me go tell a medical student that I'm checking in. Hey, I'm about to go downstairs to see this.

So I went downstairs, saw these patients, let Ashley know, hey, I'm going to be late for rounds, can we push them a little bit, or

something to that effect.

What she's referring to is information that she got from Will Crews, but it's incorrect.

Q. Next thing, talking about the two alphas, not necessarily those. But, "He did not go to traumas during the holidays."

A. Yeah, that one, I do not have an idea what she's referring to. If there was ever a time that I didn't go to a trauma, I'd like to know, because I went to every single trauma. Those things do not shut up -- those pagers go off nonstop until you go down. Someone has to show up or they keep going off and off and off. There's never a time, to my recollection, that I ever didn't go to a trauma.

There were some times that I can recall where -- this wouldn't have been with Ashley, this would have been with Meghan -- where it's a beta or something like that, and we would split those up. So Will would go to a beta, I would go to a beta. Will would go to another beta -- Will Bruch would go to a beta, I would go to a beta, things like that. Will Crews had no responsibilities whatsoever on the service.

A medical student's responsibility is

just to learn. We would split those up, so sometimes I wouldn't go to those or whatever. There was never a time that I just, you know, wouldn't show up and there wasn't coverage already for it or something like that. To that, I would love to see any sort of specificity on that, a patient that I didn't go and see.

Q. "He tried to send a patient home walking to car whose car was across the street at the VA despite several nurses telling him the patient was not competent."

A. Actually, you know what, I've got a text message to that. I don't know if it's been sent to you or not. I'll certainly send these to you. I'd like to read that, because it's kind of troubling to read these sorts of things when I'm trying to do the best thing for my patients. So I'm going to read you a text message between myself and Ashley Griffin.

MR. MORGAN: Make sure you say the date of it.

THE WITNESS: I will.

Okay. Would you mind just rereading me --

Q. (By Mr. Whitfield) "He tried to send a

patient home walking to car whose car was across the street at the VA despite several nurses telling him the patient was not competent."

A. Okay. So --

Q. What's the date?

A. December 30th, 2016. And it's 5:11 p.m. She writes to me -- Ashley Griffin writes to me, "Transfer Fonville to ortho." I respond at 5:13 p.m., "Done." And then I have another text message, "Discharge nurse was refusing to do it. His nurse is continuing with the discharge. Last dose of Ativan was 10:39 a.m. I told her it came from a chief." That was at 5:57 p.m.

Then, again, I texted her at 6:05 p.m., "Now they're calling the attending. I said that was fine." She writes at 6:15 p.m., "Uro," and then again at 6:15 she writes, "Yep."

Q. Uro?

A. Yeah, urology.

Q. Okay.

A. But she just writes "Uro." U-R-O is all she wrote. Then the "yep" text that came next at 6:15. And then subsequent to that at 6:17, she wrote, "Does he need a ride? Is that the issue?"

At 6:18 I wrote, "He's going to drive himself home. He has his car here parked at the VA."

She writes at 6:18 p.m., "Hold benzo and DC in a.m. They won't clear him to drive." 6:19 p.m., "It was discontinued. I'll discontinue the DC," meaning discharge, I didn't -- "I'll discontinue the DC, but he will probably leave AMA." Then at 6:26 p.m. she wrote, "K."

So, to me, it's troubling when I'm informing -- which is exactly what an intern's supposed to do. There's an issue on bringing this to my senior resident's attention. I'm giving her the exact information that I have. I'm letting her make the decisions, you know, keeping her abreast. Everything basically that she said is in the text messages here except for the context that I'm the one bringing it all up to her. I'm not trying to discharge. I'm asking her what she wants to do. That seems kind of willful --

Q. Without having -- I had heard you read them. Had you already done the discharge papers and she told you to cancel them?

A. Yeah. So she wrote "hold benzo" at 6:18 p.m. She wrote, "Hold benzo," which is a mind-altering drug. Benzo is kind of like

alcohol.

Q. Benzodiazepines?

A. Yeah, it's a classification of drugs. Ativan, which I mentioned earlier, is a benzo. It can give you the same affect as getting drunk. She says, "Hold benzo and DC in a.m." DC means discharge, in a.m. And then I said at 6:19 p.m., "It was discontinued. I'll discontinue the DC, but he will probably leave AMA." AMA means against medical device.

Q. Was he trying to be discharged originally in the evening and she said hold it until in the morning?

A. That's right. That's what she's referring to, that I tried to send a patient home who had his car over at the VA, and in the meantime, I'm telling her all the information. All I can do is report directly. You can twist anything. And that's what's happening here, is you use something that's completely innocuous, I did exactly objectively what anybody would want me to do, and that's relay the information as it's happening. I'm telling her, you know, the nurses are -- now they're calling the attending. I said that was fine. When they're threatening to call

the attending, that's, okay, we disagree with what you're telling us. And I'm saying this came from the chief.

So they were threatening to call the attending. I said that's fine. And I let her know that, too.

Q. I guess I'm not understanding the timeline of what you're telling us. Let me walk through what I've heard and you tell me where I go wrong.

A. Sure.

Q. So you were discharging the patient?

A. According to what she had told me to do, yes.

Q. And the nurses are saying, no, this patient can't go and they're calling the attending. Then you contact Ashley and say the nurses are -- I told them it's fine, they're contacting the attending. She tells you to stop the discharge until in the morning and you said she's going to leave without medical advice.

A. She says --

Q. Is that the general gist of --

A. Yeah, she asks a few questions. Does he need a ride? Is that the issue? And then I tell

her he's going to drive himself home. He has his car here parked at the VA. Then she says, "Hold benzo and DC in a.m. They won't clear him to drive." And then I said, "It was discontinued," meaning the benzo was discontinued. And then I say, "I'll discontinue the DC, but he will probably leave AMA," to which she responds at 6:26 p.m., "K."

So I couldn't have given her any more information, been any more transparent, relayed anything more accurately and honestly than what's there. But this is kind of pattern and practice where you do something and things get twisted and, you know -- I certainly am not -- I don't think I have anything at all to be ashamed of in this exchange here. I was relaying the information exactly as it was being told to me.

Q. According to the text, you had already tried to do the discharge, the nurses wanted to call the attending, and then you brought Ashley in the loop and she said to discontinue the discharge?

A. No.

Q. Where am I missing the step here?

A. On rounds, we go through and we talk

about who needs to be discharged, things like that. So we agree this person needs to be discharged, this person needs to be discharged. So I would have been told by Ashley on rounds with Ashley and the attending this person needs to be discharged. I write that down, I notate it, and in addition to all the other things that I have to do for all the other patients. So when I got this patient, I put in this discharge, as I had been asked to do, and then all this stuff started to come up. And as it started to come up, the nurse was like -- I don't remember the exact conversation with the nurse, but she's telling me, we don't like this. Some variation of that. We're going to contact the attending. I said, that's okay. I've been told by the attending and the resident -- this is coming from the resident, this person is good for discharge. If you want to speak to the attending, that's fine, they'll say the same thing. And then I let her know more and more.

So she had been on board, but she didn't know about, you know, the new updates until I updated her right after I knew about the updates. So to portray that as if I was just doing this

independently and trying to do it on my own, he tried, that's just not true.

Q. And then there's one about a wound washout.

A. A wound washout, yes.

Q. Instructed you to wash out a wound. Ashley testified at the hearing that she had to come back in later and do it, that it had not been done.

A. Right. So the wound washout -- again, I don't have the patient's records for any of these other than really the decubitus ulcer. The wound washout, my memory was, this patient came in unconscious. She was a large woman who had been ejected from a motor vehicle. She came in unconscious. She had a shoulder that was hanging on basically by the skin on the top of her shoulder -- I'm sorry, an arm that was hanging on by the skin on the top of her shoulder. I went in, I examined her, everything like that. She was eventually moved to the ICU.

At some point somebody asked me to go and wash it out again. So she had the wound washed out by the emergency room, then they packed it a certain way, and then I was told to go in and

rewash it, do kind of a more thorough wash. The ER, they're going quickly, they're trying to get things done. So just go in and do a more thorough wash.

What I remember is, I went into the room, there was an ophthalmology resident at the head of the bed suturing one of her lacerations up at the head of the bed. He was already sterile. This is all done sterile. I had come in, do you mind if I start prepping? He was like, no problem. I think he was starting to run out of suture. I told him -- he told me, hey, you're not scrubbed in yet, right? And I was like, no. He said, would you mind getting me some suture from my bag? I said, yeah, no problem.

So I got him some suture from his bag. We were talking. I handed it to him sterilely. In order to give it to him, if you give it to him in such a way that he can maintain sterility, things likes that. So he was able to get his job done without having to scrub out, lay everything back out again just to put a couple more stitches in. So I ended up saving him probably 15 minutes, something like that.

Then once he was done with that, I

started on mine, washed out the wound. At some point I got a text message later -- I didn't tell anybody because you just go and do it, check it off the list, you're done. That's how everybody operates. You wouldn't drop in a note, you're not going to, hey, I did this. You don't let everybody know every single step that you do in a day.

And I got a text message from Sid Desai. Sid Desai said something to the -- I'm paraphrasing, but something to the effect, did you wash that wound, wash that patient out? I texted him, I said, yeah, I've already done it. I think by that point I had already left. I did it, I'm already gone. I left two minutes ago, something to that effect.

Q. He said, you wash that wound out or what?

A. Yeah, something like that. I said, yeah, I did it. And I already left like two minutes ago. Shift change had occurred, I signed out my patients, there was no issue with that. And I don't know how I found out, but he had done a wash himself. I think he told me or maybe it was in the text message. I don't recall exactly

something, but he had done a wash. So at this point it's ER wash, I wash, Sid washes.

And then in the appeal -- I didn't hear anything more about this, you know, like specificity, that I can recall, until the appeal when Ashley came in, and Ashley was saying that I had been -- that I had not done it even though I said I had, and I had left her to do it and she was pulling sticks and twigs and whatever rubble, pebbles out of the wound, things like that.

Now, where it's inaccurate is she forgets in one of her own e-mails, one of those very e-mails, she notes that she -- she said, I left Sid and later herself to clean out the wound. So she's using -- pulling sticks and twigs out of the wound as evidence that I didn't do the wash. She would also be criticizing the quality of the wash from her own co-senior resident, Sid Desai. And she neglected that -- she neglected to mention Sid Desai at all ever doing a wash in the appeal at all. So, to me, that's evidence of, you know, an inaccuracy, what we can call it.

But no, I always did it. I always maintained that I did it. I did do it. Sid did it. And then later on down the line, things are

changing to where Ashley's saying I had to pull sticks and twigs out. And I'm not denying or downing that she did. Fluid, gravity tends to settle things. Like I said, she was a large woman, things can travel in the layers of fat and muscle, anything, things can get in there and you might not see it perfectly. Gravity, time just settles things out. The fluid just kind of rushes things out.

So I'm not denying that it happened, but if you're going to use that to say that the quality of my wash -- I couldn't have done a wash if she was pulling that out. She's also calling Sid Desai a liar because she, on her own, in an e-mail said that Sid had -- leaving Sid and later myself to wash.

Q. But you heard her testify to all of that at the hearing, that she had to come in it still had the ER dressing on it and --

A. Yes. If you're discussing the ER dressing, Sid would have come after me. I don't know what he put on. You can stop off and get a dressing anywhere. I don't know. I know that I took the dressing off. I know that I packed it. I know that I did the wash. If we get that

record, I'd be happy to try and get the name of that ophthalmology resident and see if you can talk to him. He might remember me.

But, you know, I never saw her after that, so I don't know what she was seeing or whatever. But that would have been Sid's wash that -- by her own admission, that would have been Sid's wash that she was then looking at, not mine. Or Sid's packing of the wound that she had been looking. Sid would have taken mine off.

Q. After hers -- after the wound washout, then we get an e-mail from Meghan Mahoney. I'm sure you've seen that one as well, where she lists off basically talking about the decubitus ulcer again, correct?

A. That's correct.

Q. Talks about going for a run?

A. Do you have a copy of that e-mail that I could see?

Q. I do. You can take that one. We'll make that whole thing the next exhibit.

(Exhibit 17 marked for identification.)

Q. (By Mr. Whitfield) We'll make that whole stack.

A. I see that e-mail right here on 17, 445,

he left Sid and later me to do it. It's on 445, Exhibit 17.

Going back to the one that you were referencing --

Q. Go back to that. She left leaving Sid -- she doesn't say that Sid did it, she just said you left it for him, and then later for her. Whether he did it or not, it doesn't really say.

MR. MORGAN: I would disagree. It says he left leaving Sid and later me to do it. That certainly insinuates "and later me to do it." "And" not "or."

THE WITNESS: And the other thing is, wouldn't Sid be guilty of the same thing that I did. I mean, I did it and Sid did it, but if you're leaving things and lying about it, like leaving them for later, then we would, at the very least, both be guilty of, you know, advocating duty or leaving responsibilities open.

But going back to this, yes, I have seen this e-mail through the course of discovery. No. 1, I mean, I think we talked about this, going for a run. What you don't see here is, you know --

Q. (By Mr. Whitfield) First text

permission --

A. Exactly. That, to me, is misleading. I told that to Earl from the very beginning when he met with me earlier in December. You know, but she doesn't even notate that. She never told him about that, because he told me he didn't know about that, you know. So that's absolutely just intentionally misleading to me.

I was told that in '19, in their second year that Joe didn't respond --

I'll just let you go. I don't know what you want me --

Q. That's the code blue that we talked about in No. 2.

No. 3 was about logging cases. You have to log procedures; is that correct?

A. Yeah, that's right. So now that I've been kind of on the other end, like in the business world, this is like the equivalent of logging your expenses. It's something you have to do, it's something that needs to be done. It needs to be done accurately. It's sort of the last things that you think about. As long as you're keeping track of it, all you have to do is update this database.

I probably was delinquent in doing it a few times. But from what I recall, you know, I said that I had -- this came up to Meghan, Meghan brought it up to me from Renee. I said that I had done it because I had done it. Turns out that was true. So what Meghan is saying here was untrue or -- what Renee -- I don't know where the breakdown is, but the fact of the matter is, my cases were logged.

Q. No. 4 is another one about the nurses and your interactions with the nurses.

A. Just give me a second to read this one. This -- again, I had never personally had any sort of complaints brought to my attention from three north nurses. And to my knowledge, there are no documented complaints dealing specifically with me. I do know that throughout that month there were things that were --

Like Will Bruch and I, the other resident, looked very similar. I guess two tall white guys. So they would get us confused. There was an instance -- here, I can read this one in, too. Let me just pull it up. I don't know if it's been produced or not, but we can certainly do that, too.

MR. WHITFIELD: I'd ask that he produce all the text messages that he's got with our people.

MR. MORGAN: I thought we did.

MR. WHITFIELD: I don't have any of these.

MR. MORGAN: Which one?

THE WITNESS: This one is Will Bruch.

MR. WHITFIELD: The ones with Ashley Griffin and all that --

MR. MORGAN: I'm not sure if all of them were formerly under the request, but I'm happy to produce --

MR. WHITFIELD: They should have been in disclosures.

THE WITNESS: So this is December 15th. I said at 5:57 p.m., I said, "Thanks, dude." Next text message at 5:57 p.m. again, I write, "I'm in wiser checking on two turds." That was Meghan Mahoney's nickname for one patient. And then at 6:56 p.m., I wrote, "You need any help?" At 7:43 p.m. he responds to me, "No. Hahaha. One of the three north nurses reportedly claimed she overheard me say trauma nurses are dumbasses."

Yeah. So there were comments --

certainly it wasn't just me. I never had a complaint like that, to my knowledge, that I had ever said anything rude like that about a nurse. This isn't to, you know, point out anything that Will Bruch did or did wrong, but to say that this is only happening with me, that's not true. There were also a lot of comments that were attributed to me that were him. People confused us a lot.

And no point did she ever bring up to me like, hey, these are some specific nursing complaints or nurses are complaining about you, nothing like that. No one ever said anything to me.

Q. (By Mr. Whitfield) And then No. 5 is back to Will Crews again. That's relating to what we talked about Will Crews?

A. Yeah. You know, I think with Will Crews -- I mean, I just gotta tell you, I struggle to find something that was accurate about what he said. The sexual harassments thing that was also brought up when he said that -- in the appeal, the appeal being the one at UMMC, when he relayed that he had been told by this female medical student firsthand that I had made her uncomfortable, whatever. And then subsequent to that, you know,

in his deposition, I heard that he --

The whole time I'm struggling, where is this coming from? And then in deposition, now the story changes to, oh, a resident told me. I don't remember which resident. Now it's changing from being firsthand information to third or fourth or whatever hand information. Now, you know, it's not that he heard directly.

So Will Crews, I have a lot of trouble finding accuracies in what he said.

Q. No. 6 is the decubitus ulcer patient we went through.

A. Yes, we did talk about the decubitus ulcer patient. Yes.

Sorry, I just wanted to -- "For two weeks Joe told me that a certain patient did not have any skin changes." So, again, she's saying that I never saw a wound, and she kind of reverses herself even in her own testimony, she's saying here for two weeks in writing, "Joe told me that a certain patient did not have any skin changes. Wound care saw patient and reported sacral decubitus they felt needed to be debrided. It wasn't until they placed a note that Joe told me the guy had a wound."

I mean, that's just not true because wound care, Kisha Dyse, had been consulted on November 30th and placed at least two or three notes into the record prior to December 22nd. That wasn't her first note, and it also wasn't the first time that I had told Meghan about this.

And then there's also accounts, like if you go to Earl's, Earl's saying that, not that I didn't say that there was anything, I was just repeating what the wound care nurse said.

So, you know, the truth is, I had been telling her the whole time, the wound care nurse had been putting in notes, it couldn't have been any clearer. It's in my notes. I told her about it. I'm the only one with documentation of a text message telling her about it.

Q. That text message was on December 22nd.

A. That's right. But that was before it was discovered to be the big thing that it was. I thought, oh, maybe this could be something. And, you know, that was a gap in medical knowledge.

Q. It was discovered the next morning. You sent the text in the afternoon. When they looked at it the next morning, that's when it was discovered.

A. That's right. That sequence of events is correct, but Meghan knew. I'll tell you -- while we're on the topic, I'll tell you the mechanisms that Meghan would have known. On November 30th -- Sid Desai was the trauma chief on through the end of November. Whenever Sid Desai finished, Sid Desai would have given Meghan sign out on all the patients on the service for her to then take over to be the chief. That was known then. I'm sure it was probably discussed. I wasn't privy to it, but it should have been discussed then.

Then there were notes dropped in from wound care periodically throughout the month. All of us were putting in wound care -- the Wound Care Recs. We were copying all the Wound Care Recs. Everybody was aware except her somehow that this patient had a decubitus ulcer. It was in the notes, it was in all of our notes copying forward. There was no other wound that was being treated or seen. Kisha Dyse's notes are specifically without question on that decubitus ulcer wound.

When I'm not there to say anything on December 23rd, she blames me, I'm assuming, and then sends me a text message trying to trap me.

And it's unfortunate that this all has to come to this, but that's really the reality that we're dealing with here. There's tons of way that she could have and should have known. I guarantee you, there are no PGY4 at any level or at any space, you know, job description, you know, requirements, anything like that, that will tell you that she should have just completely relied on interns to provide her information. She should know her patients.

If I had ever gotten a chance to be a PGY4, you better believe I would have known about my patients in reading about them. I don't even understand how Dr. Earl or Meghan can make the assertion that it's totally fine to just not read anything, not know anything, and rely entirely on intern.

No. 1, I was telling her. But No. 2, you're relying on the least knowledgable person as the only catch for errors in the system. That makes you no more intelligent -- that makes the medical system no more intelligent than the least knowledgable person on the team. It doesn't seem like a way that you would want to design your health care system.

Q. That it?
A. That's it.
Q. Okay. You would agree with me that all these e-mails were turned in to the general surgery office or to UMC?
A. They were sent to Renee Greene, if I recall. So I would agree, yes, that they were sent to Renee Greene.
Q. These five people, Colin Muncie, Ashley Griffin, Meghan Mahoney, William Crews, they all testified at the hearing?
A. Yes.
Q. And that would be the hearing for the appeal of your termination?
A. If that's what you're referring to, then yes, I would agree with it.
(Exhibit 18 marked for identification.)
Q. (By Mr. Whitfield) I'll hand you now what has been marked as Exhibit No. 18. Is that right?
A. Yes.
Q. This is a letter signed by you and Dr. Earl on January 10th, 2017. Do you remember having this meeting with Dr. Earl?
A. I do.

Q. In this letter he gives you specific feedback and basically tells you you have 60 days to improve. Do you agree with that statement?

A. Could you say that one more time?

Q. That he's giving you specific feedback and telling you that you have 60 days to improve?

A. I would disagree with that. I do not think any part of this was specific.

Q. He tells you these concerns of you dealt with critical deficiencies in the SPB1, SPB2, SPB I -- PR1 milestones, and that you have concerns with lying and being untruthful about patient care, leaving the hospital during duty hours, dereliction of duty, unwillingness to help with tasks, condescending tone to nurses and fellow residents, and poor interprofessional communication. Is that what's in the letter?

A. That is what's in the letter. I would not consider that specific in any way. Poor interprofessional communication, again, it's a reoccurring theme of no specificity whatsoever.

I think if you'll notice going back to Exhibit 12, he essentially copy/pasted what he didn't send to me in Exhibit 12. And then in Exhibit 18 the language is almost identical. Poor

interprofessional communication, exactly identical. No. 5, No. 5.

No. 4, leaving clinics without telling anyone, now that's removed. But No. 4 is now replaced with condescending tones to nurses and fellow residents, which is No. 3 on December 20th.

Then if we go up to No. 2, leaving the hospital during duty hours to exercise, dereliction of duty. That was also No. 2 on December 20th.

You'll notice No. 1 was unwillingness to help with tasks on December 20th, that's now No. 3 here. Lying and being untruthful has now been made No. 1.

So the major difference is some rearrangement. Looks like he's trying to add like an order of importance to these now. He added lying and being untruthful about patient care, and he subtracted leaving clinics without telling anyone.

So going back to the question, I don't think this was specific at all and, you know, there's new things that are coming up to which there was no specificity even to the new things, still to the old things. And there are things --

I don't know if this means -- leaving clinics without telling anyone, is that no longer important or is that -- I don't know. Why did he carry forward some of these and not others?

And then in terms of the critical deficiencies, SBP1 means just that to me. I don't know what that means. Systems-Based Practice, I know that's probably what SBP stands for, but I don't know what that -- no surgical resident expected to have that memorized. You know, there's no sort of specificity to anything. I don't know how --

If I take my car in, for example, and I say, hey, the brakes don't work, they know to look at the brakes. When someone tells me there's poor interprofessional communication and I'm not seeing any sort of poor interprofessional communication, it would be great to have some specificity so I could fix that. That's what I wanted to do, and I never got it.

Lying and being untruthful about patient care, he wouldn't tell me about it. It was almost like he wanted me to fail. I don't know why -- I played sports and things like that. When I messed up in anything else, I think that's part of why,

you know -- part of how you get better. Whenever I messed up on a sports team or anything and someone tells me I did something wrong or I ask, they tell me what I can work on and fix it. That's what a coach does.

It's really kind of what a program director is supposed to be, and I was never getting that. Lying, being untruthful about patient care. You would think that would be a no-brainer for somebody to tell that person exactly what it was regarding, but that never happened. So no, I disagree that there was any specificity to this.

Q. And then he comes in and says -- I don't know how you want to count the paragraphs. One starts on Tuesday, December 20th. He refers back to the meeting that you're referring in the e-mail. That y'all met and discussed the issues.

A. Yes. So on December 20th he refers to that. What was your question?

Q. He references that in the letter, the meeting on December 20th.

A. Yes, but -- and again, it's misleading here. "On Tuesday, December 20th, 2016, we met (with Renee Greene present) and discussed these

issues."

That's not true. The list that he -- he never sent me this list. But the lists aren't the same. So if the lists change, probably a pretty good indication that we didn't discuss these things. Lying and untruthfulness, never discussed with me. These other things, yes, they were brought up, condescending tone to nurses and fellows. Same thing with poor interprofessional communication and leaving the hospital during duty hours. They were all just brought up. And that was it except for the leaving the hospital duty hours. He had information on that. We talked about that and I gave him more information. And discussed these issues, that's patently false. Look at the two documents. They're different.

Q. He says, "This meeting is in addition to several other meetings, including but not limited to, the semi-annual review." Did you have that semi-annual review?

A. We did have the semi-annual review, but it seems what he's trying to do is incorporate all of these items that came previously in this January 10th contract letter, whatever you want to call it, into all of these discussions, and it's

just not true.

Q. Did you get feedback from senior residents?

A. Not really, no, not that I can recall. Specific feedback from senior residents where I was sat down and we talked about issues. I mean, I got yelled at by Meghan. I got -- many times.

There was one time about the code blue where I sought kind of the advice from a more senior resident who wasn't on my service. He was just kind of friend within the program. And I asked him, hey, man, these are the circumstances, what do you think about this? And he told me, you didn't do anything wrong, something to that effect. But if you ever find out, if this happens in the future, just call whose patient that is. I took that advice from him and I agreed with him. Call next time -- if it's a floor, I think he said -- if it's a floor -- if it's a floor with many of your patients -- you service with your patients on it, just call next time. Good feedback. And I would have from that point forward.

But any sort of formality with senior residents, sitting down and talking to them, no, there was never any meetings. There was the chief

resident meeting that I called to talk about Josh Sabins. That wasn't to give me feedback, it was to relay information from me to the chief resident.

Q. And you said you don't remember the meeting in late November outside of OR-16?

A. I don't think it occurred, and I don't recall it.

Q. At all?

A. At all.

Q. You didn't object to that being in here on this letter when you signed it?

A. Oh, I did. I objected to basically everything. I told him, you know, this isn't -- I can tell you straight up right now, patently false that I ever lied and was untruthful about patient care. But it would be great to get some context around that so I could know what you're talking about, maybe we can clear this up. Where did it happen, everything. He became angry.

Q. Did y'all talk about this decubitus ulcer patient?

A. Not a single time in this meeting or prior to it, ever. Not once. And I asked him, never would tell me. Told me, I don't need to

tell you, this is -- whatever, this is what it is. I said, okay, do you mind if I take this contract? I'd like to take some time and look over it and have somebody else look over it. He told me, sure, but you're fired if you don't sign it right now.

So I objected a lot to a lot of this, and he just didn't let me -- if I didn't sign it, I was fired right then and there on the spot. And he also said if I didn't go and get the fitness for duty exam that he was going to take me to afterwards, I was fired on the spot then, too. So I went and did that, too. Everything was under the threat of immediate dismissal.

Q. And then after this you were placed on administrative leave? You didn't work after the 10th?

A. Yeah, let's call it that. I did not work after the 10th. I don't know what the term is or anything like that, but I did not work another minute after this.

Q. But you were still getting paid from the 10th to your termination date?

A. That's correct.

Q. What do you call it, suspension leave,

whatever, you were being paid, but you weren't working after November 10th --

A. Right.

Q. Excuse me, January 10th, correct?

A. January 10th until -- yes, I was still getting paid.

Q. At some point you had a meeting with Human Resources?

A. Yes, that would have been on January 27th, if I recall correctly.

Q. And that's reflected in the transcript that we've already entered into evidence. I can't remember the exhibit number.

A. Yes. One thing I would like to point out that's come out, you know -- I don't even drink. So for someone to say that I've got a happy hour to go to, you know, that's untrue. That was off the record, too, that -- what they're saying is when I called them to figure out where HR was, that happened. It was off the record. Everything else in the record, you know, that is what it is, it's in the record. But I never called and said I've got a happy hour to go to. I don't even drink, so I wouldn't have a happy hour to get to.

Moreover, at that point I was on the outside looking in. I'm not from Mississippi. I don't know anybody from Mississippi. So I wouldn't have had -- my friends were residents, but by that point I'm on the outside looking in. So who would I have had to get to happy hour with? So I just wanted to mention that.

Q. And then subsequent to that, you were terminated on February 22nd?

A. That's correct.

Q. And then your attorney wrote to the Med Center requesting an appeal?

A. Yeah. And then in the meeting, I'd just like to state in that February 28th -- February 22nd meeting with Dr. Earl, the termination meeting, I knew what was happening. As he was getting started -- before he had said you're fired, you're terminated, whatever it is that was said, I said, is there any chance, any possibility to resign? He told me, no, it's already passed through legal, it's already passed through HR. This is what I want. You're done.

I said, okay. I can't possibly resign?

No.

Then he told me, we're letting you go,

you know, you lied about patient care. We can't trust your integrity anymore. About the decubitus ulcer. I told him, that's not true. But this is a battle for another venue, I guess. Is there anything else? He told me, no. And that was the end of the meeting, basically.

Q. Do you remember him asking for your badge?

A. I do.

Q. Did you give it to him?

A. No, I didn't.

Q. Why didn't you give it to him?

A. I had lost my badge prior and I had just paid 25 bucks for it, and I just wasn't really inclined to give him the badge. He didn't provide me with any sort of documentation -- not that there's a reason for that. This is just in addition, you know, period to the last statement, separately. He didn't provide me with any sort of documentation. He didn't give me anything whatsoever. He didn't have anything prepared that it looked like. It didn't look like he was ready to hand me a piece of paper, anything like that.

I asked him if there was anything else. He told me, I can't trust you no longer. A lack

of integrity. So no longer trust you anymore. I said, that's not true. We already went over this. He didn't hand me any documentation or anything.

I was like, my dad owns Subways. They get more ceremony when he lets somebody go than I got. To the extent to which I was given any sort of documentation, any of sort of information, none really.

Q. That happened on the 22nd?

A. That's right.

Q. Then your lawyer on the 3rd sent in a letter requesting an appeal?

A. I don't recall the date, but that sounds right. He did at some point, yes.

Q. Between that time and the hearing, did you ever receive word that UMC had offered you the opportunity to resign?

A. No. Sorry, between February 22nd and March the 3rd you're saying is the date?

Q. No. The hearing.

A. The appeal hearing, like July 17th or whatever that was?

Q. Correct.

A. No, never.

Q. Are you aware that it was offered to

your attorney?

A. No.

MR. MORGAN: I want to object because --

MR. WHITFIELD: I know we disagree on that.

MR. MORGAN: From the plaintiff's position, it was allegedly offered to his previous attorney.

MR. WHITFIELD: Fair enough.

THE WITNESS: I found out -- just to be clear, this was not known to me until whatever deposition it was that you brought it up to Greg, I believe. You brought it up to Greg and Greg relayed the information to me. I told him -- it's attorney/client privilege, but I'm telling you, no, I --

Q. (By Mr. Whitfield) You were unaware?

A. I was unaware.

Q. That's all I was asking.

A. Okay.

MR. WHITFIELD: Let's take a five-minute break real quick.

(Off the record.)

Q. (By Mr. Whitfield) Do you know who Dakota King and John Shaughnessy are?

A. Yes, I remember them. They were M4s -- fourth year medical students at the time.

Q. What service did you work on with the two of them?

A. You know, I don't recall. I don't recall.

Q. Do you recall working with them?

A. I do.

Q. They have both come up and have now said that during their time working with you, you would log into the Epic system, the electronic patient medical record system, and they would write notes for you. Do you recall that?

A. I don't recall that. I recall -- I don't recall that.

Q. You don't recall it happening or -- you're saying it didn't happen or you just don't remember doing it?

A. I would say both. I would say that I don't recall it ever happening, and if it did, you know -- I don't recall it happening. I recall that being -- I don't recall myself ever doing that, but I recall that being a practice that was done. I can't remember what service, because forth year medical students don't really get the

opportunity to write notes. Their notes are meaningless, essentially. They can write a note, it's essentially meaningless.

You can co-sign their note -- this is four or five years now. You can co-sign their note, but then you still have to write one on your own. If I remember correctly, I don't remember myself specifically doing this, but it was a practice that some would do where they would allow someone to write a note on their account, then they would review that, and then before hitting submit, they would submit it. I don't recall that ever happening with me.

Q. But it's possible?

A. It's possible. At end of the day, it wouldn't have been their note, it would have been mine, and it would have been reviewed. But I just don't recall that ever happening. I've seen it happen, but I don't recall that ever happening with -- with myself. And I don't recall what service we were on together.

Q. Could it have been in the fall of 2016 when you worked with them?

A. I don't know about fall -- when is winter, December?

Q. I guess it would be the 2016, the first half of the first year. You weren't here for the second half?

A. Yeah, I was here through a little bit of the beginning of 2017, through January 10th of 2017. I don't think it was on that service. So yeah, it would have been I guess the second half of 2016, at some point, I was on with them, because I remember the two of them.

Q. Now, when you had the appeal hearing, when it was scheduled and Dr. Bondi was the chair -- do you remember having that hearing?

A. I do.

Q. Now, you didn't come in person to the hearing?

A. That's correct.

Q. You telephoned in remotely, or conferenced in?

A. Yeah. I was given a phone number, I just called into it.

Q. But your attorney, Joel Dillard, was physically present?

A. That's correct.

Q. During the hearing y'all would take breaks so that you could have an opportunity to

consult with Mr. Dillard?

A. That's correct.

Q. Do you remember at the beginning of the hearing when Dr. Bondi was reviewing how the proceedings would go?

A. Give me a little more detail.

Q. You remember him saying that the expectations would be that you would call and question your own witnesses?

A. That I would call and question my own witnesses? No, I don't recall that. I was not allowed to call or question my own witnesses. What I believe his instruction was, was I will be allowed to state a question to the committee and the committee can then decide if they would like to pose the question to the witness, which they never did.

(Exhibit 19 marked for identification.)

Q. (By Mr. Whitfield) I'll hand you now what has been marked as Exhibit 19, transcript of the hearing. I want to refer you to the bottom -- I'll use the bottom Bates number Papin 064. The actual page 9 of the transcript.

A. Sure.

Q. I want to point you out to lines 14

through 18 where your lawyer is talking with Dr. Bondi and asked him, "So the expectation will be that Dr. Papin would call witnesses and question them himself?" And Dr. Bondi responds, "Yes, or have them speak in the narrative."

Do you see that?

A. I do see that.

Q. Now, when he said this, did you tell him that you had witnesses to call?

A. No. I would assume -- what I assumed is they were clarifying the witnesses that -- you know, that UMMC had produced. So there were several witnesses that were named prior to the appeal that -- that -- I would assume you and your team produced a list of several witnesses that could speak. I would assume that I could call from those specific witnesses. But, you know, I was never given the opportunity to list witnesses, ever. I was never given the opportunity to call witnesses. There was never a point where I could call my own witnesses.

I mean, did Dr. Bondi ever open the floor to me to call any of my witnesses, because I didn't have any prep to be able -- I didn't know what the format was going to be. I didn't know

that I could call witnesses.

Q. When he announced this in the hearing, did you say, wait, Dr. Bondi, I have witnesses I'd like to call?

A. Frankly, I don't recall this being said. But I think -- what I think Joel was doing is highlighting kind of the hilarity and the format that I'm expected to be my own attorney and call witnesses and ask questions of other witnesses and things like that, do my own cross, things like that.

Q. Did you have witnesses that you wanted to bring on your behalf?

A. I certainly would have had I been given the opportunity prior to page 9 of the deposition as it was ongoing.

Q. But during this time, you nor your attorney interposed an objection saying we have witnesses we'd like to call?

MR. MORGAN: Object to the form. You can answer if you can.

THE WITNESS: Again, I don't recall hearing this. I don't recall this coming up. But what I do recall is -- what Mr. Dillard is doing is kind of objecting to the hilarity of the

format. This is a kangaroo court.

Q. (By Mr. Whitfield) When Dr. Bondi did open the floor up for you to make your presentation, you didn't say, Dr. Bondi, I've got a witness I'd like to call? Did you ever raise up to Dr. Bondi, I have a witness I'd like to testify?

A. Well, if I didn't hear him say this over the telephone, I don't know how I would have known to -- I accepted that I wasn't given the ability to produce witnesses. And having not been given the ability to produce witnesses, I wouldn't have had any witnesses to produce that very second; whereas UMMC had the ability to call their witnesses, schedule them, have then present, be there, things like that, had access to them to prepare them in any way if necessary. I didn't have that ability, so --

Q. Who --

A. Just one second. If I missed this being said, I would have never been able to object or interpose or anything like that. And frankly, this is exactly why you need an attorney present, you know, to do these kinds of things. I was never given the opportunity, I was never told,

hey, you can have witnesses, which witnesses would you like to have appear?

It sounds like it was said here. I missed it. But it's already too late here. How can I produce witnesses while the hearing is ongoing?

Q. Did anybody tell you you could not have a witness?

A. I mean, I didn't speak to anybody at UMMC. So I think the last time I spoke with anybody at UMMC was -- it wasn't February 22nd because I remember having asked about benefits, getting things like that. It was specifically about benefits. But the last time I spoke was much sooner than this. So there was never any sort of information going either way. So I was relying on the information that was being given to me.

I was told to show up. I was not told that I could bring witnesses or anything like that. And I don't know how I really would have produced witnesses. It's difficult when you don't have subpoena power or you don't have whatever else, the powers of the court, everything like that. I would have had to have reached out to

these people, and they're still employees of the Medical Center. So there's also conflicts here. And again, I was never given the opportunity to.

Q. My specific question is: Did anybody from UMC tell you you could not call a witness? Yes or no.

A. I don't know. Let's see.

Q. Prior to the hearing, did anybody tell you you couldn't bring a witness?

A. I'll answer your first question here. So as we're walking through the format, I'm starting on Papin 62, line 23. And I'll walk you through Dr. Bondi.

This is Dr. Bondi: "The specific procedure today is going to be that Dr. Earl is going to make his presentation first, then we'll give Dr. Papin an opportunity to address the committee, but not Dr. Earl. We're going to follow that by any witnesses that Dr. Earl thinks is appropriate. Dr. Papin will also have the opportunity to specifically address issues that are brought up at that time to the committee. Once that's concluded, Dr. Papin will have an opportunity to address the committee, and then Dr. Earl will have an opportunity thereafter."

At no point in Dr. Bondi explaining this does he say that I can have witnesses, does he say that I should have had witnesses, does he say that -- he certainly outlines we're going to follow that by -- we're going to follow that by any witnesses that Dr. Earl thinks is appropriate. There's no Dr. Papin thinks is appropriate line in here.

So the fact is, it was never communicated to me or my attorneys that I could have witnesses. The fact that we're walking through this line right here where he's walking us through, then my attorney clarifies a question intending to highlight the format of it for purposes -- for what I assume is, you know, to highlight the format of this is just incredibly unfair. Dr. Bondi walk through -- so, yes, there was --

To answer your question, I was given every indication that I couldn't call witnesses.

Q. Even when it's addressed on page 9, and we'll be asking questions -- talking about the attorneys -- or won't be calling witnesses. And Dr. Bondi says, the attorneys won't be doing that, but the individuals Dr. Earl and Dr. Papin can

certainly do that as necessary.

A. Like I said, I didn't hear that, but having read it now, certainly it's on the transcript, does seem to be in direct conflict with the lines I just read to you, is what I would respond to that.

Q. But you raised no objection in the hearing about, hey, Dr. Bondi, I've got witnesses I'd like to get in here? Yes or no.

MR. MORGAN: Object to the form of the question. You can answer.

THE WITNESS: This is why it would have been great to have attorneys able to speak on our behalf. I'm not an attorney, I don't have a JD. I don't know what to object to, I don't know how to defend myself. I think that's how the legal profession has flourished, because it's necessary. So the fact that I didn't object right then -- I didn't hear this. I don't know if it was breaking up, I don't know. But I did hear the beginning of this where it's just Dr. Earl's witnesses, and I never saw any sort of communication that invited me to provide names of witnesses.

Q. (By Mr. Whitfield) Did your attorney on your behalf make any objections during this time

when he's talking to Dr. Bondi saying, hey, we've got witnesses we want to call?

MR. MORGAN: Also going to object to the form of the question, but you can answer.

THE WITNESS: I think he made an objection just overall to the format. I'd have to look through. I don't recall exactly where it was.

Q. (By Mr. Whitfield) I want to refer you to the bottom of page 9.

A. Page 9 of the transcript?

Q. Yes. He says, "Okay." He doesn't say, hey, we've got witnesses, hey, we've got other people.

A. I guess my question -- that's on the transcript. My question is, for argument sake, if I did have a witness there and ready, what would we have done?

Q. Dr. Bondi told you.

MR. MORGAN: Object to the form, but go ahead.

THE WITNESS: I would have had somebody on the line, and I would have been able to present them just -- because there was no procedure for this outline. I mean, there's no notice given.

You can just take witnesses. This doesn't seem to be the format of the hearing as it was proposed to me. It certainly wouldn't seem fair to UMMC for me to just jump in with a witness.

Q. (By Mr. Whitfield) You had the assistance of counsel at this hearing?

MR. MORGAN: Object to the form. Go ahead.

THE WITNESS: I did not. I had a counselor present, but not his assistance. I had to question witnesses on my own. By question witness, I mean I could state questions. They never answered them. I could -- Dr. Earl had the ability to -- it was like semi-prosecutorial fashion. He had opening statements. He -- he acted, you know, like a prosecutor, essentially.

I've never been through one of these. I don't know where to have objections. I don't know where to have anything. My attorney was not allowed to speak at any point. He had an objection at one point, something like that, you know.

Here Dr. Bondi, page 10, Papin 65, "He is not going to be cross-examining the witnesses, which I think is what you're getting at." I'm not

really allowed to do anything. I can state my case and hope and pray that people would investigate what I was telling them, and realize that no investigation had been done. I'm putting pretty much everything -- I'm contesting pretty much everything they said, and hoping and praying that someone will listen and investigate it, but it just never happened.

So to answer your question, no, I did not have the assistance of an attorney. I would have loved it.

Q. (By Mr. Whitfield) Now, y'all did confer during the hearing. You broke, I think, pretty much after every witness that testified and had an opportunity to speak with Mr. Dillard?

A. That's correct.

Q. If you would have come physically in person, you would have been there with him and been able to confer with him in real time?

A. It was still real time. We just spoke over the phone instead of in person.

Q. I'm talking about as the witnesses are testifying.

A. I mean, I guess. You still have to -- I don't think we would have done anything

differently necessarily. You still have to listen to what the witnesses are saying, you know, and an attorney who is trained is much better at identifying specific things, understanding what it is that needs to be pointed out, knowing which questions to bring up, knowing which objections to have. They're able to articulate the law. There's lots of reasons why I would have wished that an attorney were able to help me in a fashion that they usually can.

I'm still searching for Joel's objection.

Q. I'm going to switch gears for just a minute. You make claims in this lawsuit about being treated differently because you're Hispanic. What do you base your contention that UMMC treated you differently because you're Hispanic?

A. I think I was treated differently than my white counterparts. I washed out a wound, for example. Sid Desai told me that he washed out a wound, but I'm dismissed partially because of that. I have to find that out later, I'm not told about it, that's another issue. At worst, he did pretty much the same thing or he did it -- the decubitus ulcer. I did nothing more, nothing else

than Will Bruch except that I documented proof and I text messaged her, her being Meghan Mahoney, I let her know what was going on. I told her what was happening.

It was Monday, December 5th, where Mr. _____was his patient. And, you know, theoretically, that was a rollover Monday, whatever it's called. He had the opportunity to say something. Why is it that I'm dismissed? The wound care nurse has 19 years of experience, something like that, looking at these, seeing all of them day after day after day, that's her specialty. She's has specialized training. There's attendings who are going through, they were attesting to notes, they were looking at these wounds. Nobody thinks it's that bad, so why is it that I'm dismissed and Will Bruch -- Will is white. Nobody else is dismissed. That's the basis of the claim.

Q. That's it?

A. That's not necessarily it, but that's part of the reason.

Q. What else is it?

A. I think it's coming up in discovery, things like that. I think a situation is still

evolving, but those are some of the reasons.

Q. As you sit here today, what other reasons do you have?

A. I don't know right now, but we can go through the documentation. We can go through things and I can articulate it more. I think that's something that's more left to the attorneys to argue the legal basis of the claim than I do. But I gave you a couple of the reasons why I thought that I was treated differently based on my Hispanic ethnicity.

MR. MORGAN: I also do want to make a formal objection that you're sort of asking for a legal conclusion. I understand you need to investigate the facts underneath that basis.

MR. WHITFIELD: I just want to know why he feels that way.

MR. MORGAN: That's why I let the questions go, but I do want to state for the record that it is very, very close to calling for a legal conclusion.

Q. (By Mr. Whitfield) Did any of your coworkers say or make any derogatory comments towards you about being Hispanic?

A. You know, I don't recall the specifics.

I mean, it's been years. I really don't recall specifics and things like that. There was at one point Josh Sabins, he'd joke around, he would say some racist things. Not necessarily about Hispanics, but he would say some racist things. Any of the nurse practitioners could tell you they've heard him say that. They would always warn him he's going to get fired for saying racist things.

He asked me one day, what's MD stand for? I said, I don't know, Josh. What does it stand for? He tells me mini dick. Just little things like that.

I can't recall specifics about, you know, what was said about me being Hispanic or things like that. I do know that I was translating on Earl's transplant service on October, there were Spanish speaking patients on the service. I was translating what they were saying into English for the team, like that. Certainly it's on page 1 on my ERAS application. So the application to residency, page 1 right there.

Q. Did any of your coworkers know you were Hispanic?

A. Yes, I'm sure. I don't recall exactly who. It's not something I would walk in and tell them, hey, I'm Hispanic. But it came up. I don't recall with who or whatever. Certainly any of the residents that were with me on the transplant service when I was translating for Spanish-speaking patients, somebody asked me, I think it was actually Seawright on rounds, how do you know that? I went to El Salvador, I'm Hispanic, I went to El Salvador every summer from age 6 to 18, things like that.

Q. Other than that, you have no recollection of anybody saying anything derogatory to you about being Hispanic?

A. I don't recall right now. I'd have to look over notes or whatever. But as of right now, I don't recall.

MR. WHITFIELD: I think that's it.

EXAMINATION BY MR. MORGAN:

Q. I have some brief follow-up. Get the appeal transcript hearing. I'd like to turn it to page 108.

A. Bates stamp is 108?

Q. Bates stamp Papin 163. You don't need to read it out loud in the record. Toward the top

of that page, you can tell where Dr. Bondi is asking if anybody else has any other questions for Dr. Bar, because he was last witness called at the hearing and he was stepping down. Do you see that?

A. I do.

Q. And then in the middle it's talking about let's take a brief break. And then they come back, and it says -- Dr. Bondi says to you, you're on the line, "This is your opportunity to address concerns." Do you see that paragraph there?

A. Yes.

Q. Did Dr. Bondi tell you, Dr. Papin, this is your opportunity to call your own witnesses?

A. No.

Q. I want to go back to Exhibit No. 18. That is the January 10th remediation letter. On this letter, did you ask Dr. Earl if you could take that letter with you and review it?

A. I did.

Q. And what was his response?

A. No, you need to sign this letter right now or you're fired. And then I had to actually -- he wouldn't even give me a copy of it, I had to

request it by e-mail. And I got that, you know, at some point later in the future.

Q. Do you see in this letter in the middle section where it talks about you are on formal remediation and have 60 days to improve?

A. I do.

Q. You were fired before that 60 days ran, correct?

A. That's correct.

Q. At any point in time prior to being terminated, did you ever ask Dr. Earl whether you could resign?

A. I did. I asked him if I could resign at that February 22nd meeting where I was eventually terminated.

Q. What was his response when you asked him if you could resign?

A. No, we passed this through HR, we passed this through legal, and this is what I want. Some variation of that. It's already done.

MR. MORGAN: No more questions.

(Time Noted: 3:30 p.m.)

SIGNATURE/NOT WAIVED

ORIGINAL: MR. WHITFIELD, ESQ.

COPY: MR. MORGAN, ESQ.

CERTIFICATE OF DEPONENT

DEPONENT: JOSEPH PAPIN
DATE: JANUARY 22, 2021
CASE STYLE: PAPIN vs. UMMC, ET AL
ORIGINAL TO: MR. WHITFIELD, ESQ.

I, the above-named deponent in the deposition taken in the herein styled and numbered cause, certify that I have examined the deposition taken on the date above as to the correctness thereof, and that after reading said pages, I find them to contain a full and true transcript of the testimony as given by me.

Subject to those corrections listed below, if any, I find the transcript to be the correct testimony I gave at the aforestated time and place.

Page	Line	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This the _____ day of _____, 2021.

_____
JOSEPH PAPIN

State of Mississippi
County of _____

Subscribed and sworn to before me, this the _____ day of _____, 2021.

My Commission Expires:

_____ _____
Notary Public

CERTIFICATE OF COURT REPORTER

I, Robin G. Burwell, Court Reporter and Notary Public, in and for the State of Mississippi, hereby certify that the foregoing contains a true and correct transcript of the testimony of JOSEPH PAPIN, as taken by me in the aforementioned matter at the time and place heretofore stated, as taken by stenotype and later reduced to typewritten form under my supervision by means of computer-aided transcription.

I further certify that under the authority vested in me by the State of Mississippi that the witness was placed under oath by me to truthfully answer all questions in the matter.

I further certify that, to the best of my knowledge, I am not in the employ of or related to any party in this matter and have no interest, monetary or otherwise, in the final outcome of this matter.

Witness my signature and seal this the 8th day of February, 2021.

ROBIN G. BURWELL, #1651
CRR, RPR, CCR

My Commission Expires:
April 6, 2021